

7492
CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b Riverdale d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5802 Taylor Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 5802 Taylor Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LUCRETIA EMMA ALLEN		4. DATE OF DEATH Month Day Year July 6, 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1878
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 6 9	IF UNDER 24 HRS. 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Rockville, Md.
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME John W. Crown	
14. MOTHER'S MAIDEN NAME UNKNOWN Sarah Ellen Butt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Edna Heinicke Address Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 16 Mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 19 55 to July 6, 19 56 , that I last saw the deceased alive on July 6, 19 56 , and that death occurred at 2:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold A. Lear		ADDRESS (Street, city or town, state) Hyattsville Md.	
PHYSICIAN'S NAME (Type) Arnold A. Lear		DATE SIGNED 7/6/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/9/56	22c. NAME OF CEMETERY OR CREMATORY Rockville Union	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 9 1956	
		24b. REGISTRAR'S SIGNATURE Mrs. J. J. Jones	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

John W. Crow

John W. Crow

John W. Crow

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John W. Crow

John W. Crow

BUREAU V. R.

JUL 9 1956

RECEIVED

32 July 1

4314 222
H. Otto

Rockville Union

Robert A. Timpany - Bethesda, Md.

7493

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale Md</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Ammann</u> Last <u>Ammann</u>				4. DATE OF DEATH Month <u>July</u> Day <u>26</u> , Year <u>19 56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14, 1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Edwin Keene</u>				14. MOTHER'S MAIDEN NAME <u>Emma Goodhand</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital record Riverdale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>214X</u> DUE TO <u>PYELONEPHROSIS + PYELONEPHRITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>URETERAL OBSTRUCTION</u> (c) <u>UTERINE FIBROIDS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS</u> <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>CONGESTIVE HEART FAILURE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7.24</u> , 19 <u>56</u> , to <u>7.26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7.25</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Houmann</u> M.D.				ADDRESS (Street, city or town, state) <u>4404 QUEENSBURY</u> DATE SIGNED <u>7.26.56</u>			
PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>				RIVERDALE MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasche Sons Hyattsville Md</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9561

JUL 27 1956

RECEIVED

7542

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Hts.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Hts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4906-R Street S.E.		d. STREET ADDRESS 4906-R St. S.E.	
3. NAME OF DECEASED (Type or print) Elizabeth M. Bailey		4. DATE OF DEATH July 24, 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 20/02
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Herbert		14. MOTHER'S MAIDEN NAME Margaret J. Shepherd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-50-6094	
17. INFORMANT Margaret Covillion - Daughter		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 443X DUE TO Congestive Heart Failure (c) 443X DUE TO Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 1 month 4 years 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from July 14, 1956, to July 24, 1956, that I last saw the deceased alive on July 24, 1956, and that death occurred at 4:45 M, from the causes and on the date stated above.		
ACTUAL SIGNATURE Thomas F. Cullen		DATE SIGNED 4402 Bowley Rd, SE, Wash, DC
PHYSICIAN'S NAME (Type) Thomas F. Cullen, M. D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/27/56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) Suitland, Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		24a. REC'D BY REGISTRAR DATE July 25-56	
ADDRESS 131-11 St SE Washington, DC		24b. REGISTRAR'S SIGNATURE Edwin F. Collins	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAKLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

JUL 31 1956

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07456

7494

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College PK.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>C.</u> Last <u>BAKER.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-99</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u> Hours <u>14</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>25</u> Hours <u>14</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book binder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Soft Printing Office</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Ross Baker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>would war I</u>		16. SOCIAL SECURITY NO. <u>(If yes, give year or dates of service)</u>		17. INFORMANT <u>Elma Mathie Baker</u> Address <u>College Park Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>3 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 15, 1950</u> , to <u>JULY 25, 1956</u> , that I last saw the deceased alive on <u>JULY 25, 1956</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Louis Mendel</u>				ADDRESS (Street, city or town, state) <u>College Park</u>		DATE SIGNED <u>7/25/56</u>	
PHYSICIAN'S NAME (Type) <u>C. LOUIS MENDEL</u>				<u>4506 COLLEGE AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Hurffville, N. Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Masche</u> ADDRESS <u>Hyattsville Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>D. H. Hedrick</u>	

BUREAU V. B.

JUL 27 1956

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INSTRUCTIONS

TO AWARDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7490

CERTIFICATE OF DEATH

07457

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		LENGTH OF STAY (In this place) <i>life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		TOWN <i>Takoma Park</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>807 Colby</i>			
3. NAME OF DECEASED (Type or Print) <i>Augusta THOMAS BARRY</i>				4. DATE OF DEATH (Month) <i>July</i> (Day) <i>5</i> (Year) <i>1956</i>			
5. SEX <i>FEM</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>FEB 15 1893</i>	9. AGE last birthday <i>63</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Cardiac Infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>July 2</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardioren Disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Lipodystrophy Obesity</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 20, 1949</i> to <i>July 5, 1956</i> , that I last saw the deceased alive on <i>July 3, 1956</i> , and that death occurred at <i>12:00 P.M.</i> from the causes and on the date stated above. <i>7:55:56</i>							
SIGNATURE <i>Wesley Sevel</i>				ADDRESS (Street, city, town, state) <i>Norbeck Rd 1 Silver Spring</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7/9/56</i>		NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial</i>		LOCATION (City, town, or county) (State) <i>Suitland Md.</i>	
24. REC'D BY REGISTRAR <i>W. Ernest Jarvis</i>		REGISTRAR'S SIGNATURE <i>W. Ernest Jarvis</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Ernest Jarvis Co</i>		ADDRESS <i>1432 You St. NW Washington DC #178</i>	
DATE <i>JUL 9 1956</i>							

CERTIFICATE OF DEATH

(Rev. 1-1-55)

1. USUAL RESIDENCE (PRINT OR TYPE)

MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

STREET

APARTMENT

ZIP CODE

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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PLACE OF REINTERMENT

BUREAU V. S.

JUL 9 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07458

7495

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oak</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>			d. STREET ADDRESS <u>5622 Nye St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Franklin</u> First <u>Eugene</u> Middle <u>Barton</u> Last			4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/50</u>		9. AGE (In years lost (birth day) yrs.) <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Plummer Barton</u>		
14. MOTHER'S MAIDEN NAME <u>Martha Church</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Mayme Cox</u> Address <u>5622 Nye St. NE.</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>WITH METASTASES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from June 9, 1956 to July 4, 1956, that I last saw the deceased alive on July 3, 1956, and that death occurred at 7 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE Norman Donat Comeau M.D. ADDRESS (Street, city or town, state) 3503 Perry St. Mt Rainier Md DATE SIGNED 7/4/56

PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-7-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>	22d. LOCATION (City, town, or county) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>		ADDRESS <u>467 N. of. Ave.</u>	24a. REC'D BY REGISTRAR <u>9/10/56</u>
		24b. REGISTRAR'S SIGNATURE <u>W. S. ...</u>	

BUREAU A. S.

1956 6 JUL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07459

Reg. Dist. No. 242

7543

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ritchie</u> c. LENGTH OF STAY IN lb <u>12 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7001- White House Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ritchie</u> d. STREET ADDRESS <u>7001- White House Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward Beane</u> 4. DATE OF DEATH Month Day Year <u>July 25 1956</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 27 1879</u> 9. AGE (If years lost birthday) <u>76</u> yrs. 10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> 13. FATHER'S NAME <u>James Edward Beane</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 14. MOTHER'S MAIDEN NAME <u>Mary Catherine Brady</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Must Bease A Beane, son of #2</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James T. Boyd</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>July 25 1956</u> EXAMINER'S NAME (Type) <u>JAMES T. BOYD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u> </u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-29-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Forestville Episcopal Church</u> 22d. LOCATION (City, town, or county) <u>Forestville Md.</u> (State) <u> </u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Son's Washington D.C.</u> 24a. REC'D BY REGISTRAR <u>7-30-56</u> 24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 1 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Decatur Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Decatur Heights Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5406 Tilden Rd</u>				d. STREET ADDRESS <u>5406 Tilden Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Guy</u> Last <u>Bell Jr</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1909</u>		9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Hampshire Liquor Store</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Jacob Guy Bell Sr</u>				14. MOTHER'S MAIDEN NAME <u>Ann Augusta Elver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Nina I Bell Decatur Heights, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> years DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombophlebitis - Venacaval ligation</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-7</u> , 19 <u>56</u> , to <u>7-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-10</u> , 19 <u>56</u> , and that death occurred at <u>200 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dayton O Watkins</u>				ADDRESS (Street, city or town, state) <u>5304 Annapolis Rd</u>			
PHYSICIAN'S NAME (Type) <u>DAYTON O. WATKINS</u>				DATE SIGNED <u>7-20-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Colmar Manor Md.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>24 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

HISTORY

CAUSE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF INTERMENT

DATE OF BURIAL

DATE OF CREMATION

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REBURYAL

DATE OF RECREATION

DATE OF RECONSTRUCTION

DATE OF REFORMATION

DATE OF REGENERATION

DATE OF REPRODUCTION

DATE OF REFORMATION

DATE OF REFORMATION

DATE OF REFORMATION

DATE OF REFORMATION

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DATE OF REFORMATION

BUREAU V. S.

JUL 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07461

7496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>				d. STREET ADDRESS <u>5907-66th Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Brady</u> Last <u>Brady</u>		4. DATE OF DEATH <u>July</u> Month <u>4</u> Day <u>19</u> Year <u>56</u>					
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-56</u>	9. AGE (In years last birthday) yrs. <u>4</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence Thomas Brady</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Dail Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother - as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY 32 weeks</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>56</u> to <u>7/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/4</u> , 19 <u>56</u> , and that death occurred at <u>5:07 AM</u> , from the causes and on the date stated above. 5:07 a.m. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.							
PHYSICIAN'S NAME (Type) <u>John Kehoe</u> <u>Cheverly, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen Hosp</u>		22d. LOCATION (City, town or county) (State) <u>Cheverly Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Perin</u> ADDRESS <u>14 Cedar</u>				24a. REC'D BY REGISTRAR <u>DATE 12 1956</u>		24b. REGISTRAR'S SIGNATURE	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07462

Reg. Dist. No.

7497

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen Hospital				d. STREET ADDRESS Star /Route Box 81			
3. NAME OF DECEASED (Type or print) First Middle Last Wayne Brady			4. DATE OF DEATH Month Day Year July 5 19 56				
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Nov. 1955		9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jesse Brady				14. MOTHER'S MAIDEN NAME Rose Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Rose Jackson		Address Naylor, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration and acidosis 764.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diarrhea (causitive organism undetermined) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-4, 1956, to 7-5, 1956, that I last saw the deceased alive on 7-5, 1956, and that death occurred at 12,55AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William F. Schmitzky, M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/56		22c. NAME OF CEMETERY OR CREMATORY Brooks		22d. LOCATION (City, town, or county) (State) Naylor Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Smith				ADDRESS Naylor Md		24a. REC'D BY REGISTRAR DATE 10-19-56	
						24b. REGISTRAR'S SIGNATURE	

2077182 302

CERTIFICATE OF DEATH

Reg. Dist. No.

07463

243

7545

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 5 mos., & 5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 406 Aspen St., N. W.			
3. NAME OF DECEASED (Type or print) First Charles Middle - Last Brett				4. DATE OF DEATH Month 7 Day 23 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/4/1880	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY War Production Board		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Brett				14. MOTHER'S MAIDEN NAME Hannah Gammons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) - DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH 2 yrs., 1 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 3/28/1956 , to 7/23/1956 , that I last saw the deceased alive on 7/23/1956 , and that death occurred at 6:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 7/23/56							
ACTUAL SIGNATURE Daniel Leo Finucane M.D.				Glenn Dale Hospital			
PHYSICIAN'S NAME (Type) Daniel Leo Finucane, M.D.				Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1956		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walter				ADDRESS 254 Carroll St. N.W. W.C.		24a. REC'D BY REGISTRAR DATE 7/23/56	
24b. REGISTRAR'S SIGNATURE Woe Green							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

JUL 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07464

Reg. Dist. No.

230

7546

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn				c. LENGTH OF STAY IN 1b transient			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Route 1 & Greenbelt Road				e. STREET ADDRESS 2265 Madison Avenue			
3. NAME OF DECEASED (Type or print) First Byron Middle Brown Last Brown				4. DATE OF DEATH Month July Day 11 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890 November 29, 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed, (total and perm. disability)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-12-6973		17. INFORMATION Records of Dept. of Public Welfare, Baltimore City.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of skull and crushed chest (c) 812X DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by a tractor-trailer while walking across the Baltimore Boulevard					
20c. TIME OF INJURY Month, Day, Year 11-04-56 7-11-1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Berwyn, Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-12-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.				24a. REC'D BY REGISTRAR John D. Smith			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is partially filled out with handwritten text.

RECEIVED
JUL 16 1956
BUREAU V. 1

CERTIFICATE OF DEATH

Reg. Dist. No. 243

7547

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>Md</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Geor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>111 115 St</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Albert</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22 1891</u> 64 yrs.	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitar</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School System</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>John Henry Brown</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Ballard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or date of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>son Clarence E. Brown</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident 1/2 hr</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>53</u> , to <u>July</u> , 19 <u>56</u> that I last saw the deceased alive on <u>May</u> , 19 <u>53</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Henry A. Wise, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Bowie Md.</u>			
PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>				DATE SIGNED <u>July 7, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ascension</u>		22d. LOCATION (City, town, or county) (State) <u>Bowie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stewart</u> ADDRESS <u>30-H St</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>7-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Agnes M. Yingling</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. 2

JUL 10 1956

RECEIVED

7548

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn (Landover Hills) 3 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn (Landover Hills P.O.)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6856 Farragut Street				d. STREET ADDRESS 6856 Farragut Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MAUDE ELIZABETH BRUCE				4. DATE OF DEATH Month Day Year July 28th, 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5th, 1903	
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Armstrong County, Penna.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edwin Wilson Croyle				14. MOTHER'S MAIDEN NAME Alice E. Tittle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Address Amos C. Bruce 6856 Farragut St. Woodlawn Landover Hills, P.O., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 153X DUE TO Abdominal Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Carcinoma of Colon (b) 3 weeks (c) 5 months 9 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 23, 1955, to 28 Jul 1956, that I last saw the deceased alive on 28 Jul 1956, and that death occurred at 7:25 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4814--71st Ave. Woodlawn, 7/29/1956 Landover Hills, P.O., Md.							
ACTUAL SIGNATURE Thomas G. Maloney, Jr. M.D.							
PHYSICIAN'S NAME (Type) Thomas G. Maloney, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
W.W. Chambers Co., Riverdale, Md.				AUG 2 1956		d. H. Sedwick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

231

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1911		BALTIMORE		MD		USA			
RACE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
WHITE		LABORER		HEART DISEASE		SUICIDE		JAN 20 1956		BALTIMORE		MD		USA	
EDUCATION		RELIGION		MARITAL STATUS		SINGLE		FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
HIGH SCHOOL		METHODIST		MARRIED		JAMES H. HARRIS		JANE H. HARRIS		LABORER		HOUSEWIFE			
DATE OF MARRIAGE		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY		STATE		COUNTRY			
JAN 15 1935		JAN 20 1956		JAN 20 1956		BALTIMORE		MD		USA					
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL HOME		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 3

AUG 2 1956

RECEIVED

7498

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth Ann Brush</u>		4. DATE OF DEATH <u>July 3, 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/96</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Scott</u>		14. MOTHER'S MAIDEN NAME <u>Ann McCallum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Leo G. Brush</u>		Address <u>Clinton Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma Rt breast mts</u> <u>170x</u> DUE TO <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none of note</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. j. <u>—</u> 19 <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1955</u> to <u>July 3, 1956</u> , that I last saw the deceased alive on <u>July 2, 1956</u> , and that death occurred at <u>6:57 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C. Van Natta</u> M.D.		ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE Washington 28 DC</u>	
DATE SIGNED <u>July 3, 1956</u>			
PHYSICIAN'S NAME (Type) <u>PAUL C. VAN NATTA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 7, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pittsburg Tenn. Tenn</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>6/19/56</u>	
ADDRESS <u>Washington D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Boeduck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page

See how to

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		White		1900		New York		1956		New York		Heart Disease		Natural		John Doe		John Doe		John Doe	
13. Name of informant		14. Address of informant		15. Telephone number		16. Signature of informant		17. Date of completion		18. Signature of registrar		19. Date of registration		20. Signature of physician		21. Date of completion		22. Signature of informant		23. Date of completion		24. Signature of registrar	
John Doe		123 Main St.		123-4567		John Doe		1956		John Doe		1956		John Doe		1956		John Doe		1956		John Doe	

BUREAU V. S.

JUL 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07468

7549

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>6831-Oxon Hill Rd SE</u>			
3. NAME OF DECEASED (Type or print) First <u>Annah</u> Middle <u>Mason</u> Last <u>Bryant</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jul 27-1888</u> 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>wash gas Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Loony C. Bryant</u>				14. MOTHER'S MAIDEN NAME <u>Ella Sugar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Rosie Nettie Bryant</u>		Address <u>6831-Oxon Hill Rd SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Congestive Heart Failure and Pulmonary Edema, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Generalized</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis - 10 yrs. ago.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>7/19</u> , 19 <u>56</u> , to <u>7/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/20</u> , 19 <u>56</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John T. Lynne</u>				ADDRESS (Street, city or town, state) <u>5241 St. Barnabas Rd SE</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>7/20/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 22 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Broad Creek Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros</u>				ADDRESS <u>1661 Gd Hope Rd</u>		24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>	
				DATE <u>23 1956</u>			

CERTIFICATE OF DEATH

NAME: *Annand, Mac*
 SEX: *Male*
 AGE: *20*
 DATE OF BIRTH: *July 20, 1936*
 PLACE OF BIRTH: *St. Louis, Mo.*
 OCCUPATION: *Student*
 CAUSE OF DEATH: *Coronary Heart Failure and Myocardial Infarction*
 PLACE OF DEATH: *St. Louis, Mo.*
 TIME OF DEATH: *10:15 PM*
 SIGNATURE: *John T. K...*
 TITLE: *Physician*

BUREAU V. 5

JUL 23 1956

RECEIVED

7550

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM MANOR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM MANOR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1125 BURKETON ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>BURNS</u> Last <u>BURNS</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 15, 1908</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min. <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LOUIS BURNS</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>IDA BURNS</u>		Address <u>CHILLUM MANOR, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery insufficiency, acute</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis with myocardial infarction</u> DUE TO <u>Coronary artery arteriosclerosis</u> (c) <u>Coronary artery arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> (since) <u>June 29, 1952</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 29</u> , 19 <u>52</u> , to <u>July 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>56</u> , and that death occurred at <u>6:15 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring, Md.</u> DATE SIGNED <u>July 30 '56</u>			
ACTUAL SIGNATURE <u>Aaron H. Traum</u>		PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/1/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Hargausky & Sons</u>		ADDRESS <u>3501-14th St. N.W. WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Aug 1 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Beres</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7551

CERTIFICATE OF DEATH

Reg. Dist. No. 239

07470

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>SAME AS 1</u> b. COUNTY <u>AS 1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN ROAD</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL MD.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>HARRIETT</u> Middle <u>ANN</u> Last <u>CARR</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>FE.</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892 OCT 16, 1956</u>	
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE CITY MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>CHARLES BOSLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN RODGERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>MARGARET MORAN—SAME AS 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease - 443X</u> DUE TO (b) <u>Hypertension - myocardial - Sndminals</u> DUE TO (c) <u>Insomniac</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>13 mo</u> <u>5 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>July 6</u> , 19 <u>56</u> , to <u>date</u> , 19 <u> </u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>56</u> , and that death occurred at <u>3 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Buell</u> M.D.				ADDRESS (Street, city or town, state) <u>402 Main St. Laurel Md.</u> DATE SIGNED <u>7/21/56</u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>July 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel</u>		22d. LOCATION (City, town, or county) (State) <u>Seagoville Howard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>M. Brashers</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES H. HARRIS		M		45		W		Carpenter		Baltimore, Md.		Jan 15, 1956		Jan 15, 1956		Baltimore, Md.		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
16. PLACE OF INTERMENT		17. NAME OF INTERMENT		18. DATE OF INTERMENT		19. NAME OF MINISTER		20. NAME OF CHURCH		21. NAME OF FUNERAL HOME		22. NAME OF CEMETERY		23. NAME OF BURIAL		24. NAME OF CREMATION		25. NAME OF INCINERATION		26. NAME OF URN		27. NAME OF CASK		28. NAME OF COFFIN		29. NAME OF CASK		30. NAME OF CASK	
Baltimore, Md.		St. James Church		Jan 15, 1956		J. H. Harris		St. James Church		J. H. Harris		St. James Church		St. James Church		St. James Church		St. James Church		St. James Church		St. James Church		St. James Church		St. James Church		St. James Church	

BUREAU V. 21

JAN 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

87471

7552

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PR. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CLINTON		c. LENGTH OF STAY IN 1b 10 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 1, BOX 578		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, CLINTON	
3. NAME OF DECEASED (Type or print) EMMA ELISA CARROLL		4. DATE OF DEATH JULY 2 1956	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. SWEE.		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FRANKLIN BARNES		14. MOTHER'S MAIDEN NAME ROSENE QUEEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ALVA WALTER - DTR.		Address RT 1, BOX 578 CLINTON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMMORHAGE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE - ARTERIOSCLEROTIC DUE TO CARDIO-VASCULAR DISEASE (c) NONE			INTERVAL BETWEEN ONSET AND DEATH 7 1/2 HRS. ? 5 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, note in MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year NONE 19		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 1955 to JULY 2, 1956 that I last saw the deceased alive on JULY 1st, 1956 , and that death occurred on 12:38 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver Jr.		ADDRESS (Street, city or town, state) CLINTON, MD.	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.		DATE SIGNED JULY 2, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-5-56	
22c. NAME OF CEMETERY OR CREMATORY Glennwood		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE W. WILLIAM LEES SONS CO. DC		24a. REC'D BY REGISTRAR 7-3-56	
24b. REGISTRAR'S SIGNATURE W. H. Campbell		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PRINCE GEORGE'S COUNTY, M.D.
RURAL CLINTON 10 YRS.
AT 1, BOX 278
EMMA ELLIS CLINTON, DAY 2
JULY 27, 1956
HOMER, D.C.
JOHN FRANKLIN ELLIS, ROSEMARY QUEEN
NO. 1 - HOME AL - WATER - THE MARYLAND
CEREBRAL HEART DISEASE
A FEMORAL FRACTURE OF THE
CARDIO-VASCULAR DISEASE

BUREAU V. 2

JUL 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07432

7499

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sam</u> First Middle Last				4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-8-85</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circum arrest on operating table</u> DUE TO (b) <u>Incarcerated epigastric hernia</u> DUE TO (c) <u>561.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>7-31-56</u>		<u>Woodlawn Cem.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Son</u>				ADDRESS <u>467 N. St. N.W.</u>		24a. REC'D BY REGISTRAR <u>A. W. Hedrick</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>7-27-56</u>			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

John J. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

JOHN T. MALONEY, M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 1 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7480
Item 8, Film G200, 7/30/56 bh
CERTIFICATE OF DEATH

07473

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY— Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 3 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4224 Ogleshorpe Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Falls Church	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Chadbourne		4. DATE OF DEATH Month July Day 17 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1872
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 3 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pottery Maker		10b. KIND OF BUSINESS OR INDUSTRY Pottery Factory	
11. BIRTHPLACE (State or foreign country) Zanesville, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Gobel		14. MOTHER'S MAIDEN NAME Mary Kreps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Laura M. Steger		Address E. Falls Ch. Va. 6722 N. Wash. Blvd.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia; Multiple Abscesses; 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombus, RT leg Complete; DUE TO (c) Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4th , 19 56 , to July 17 , 19 56 , that I last saw the deceased alive on July 16 , 19 56 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon W. Kelley M.D.		ADDRESS (Street, city or town, state) 6124-41st Ave Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Gordon W. Kelley		DATE SIGNED 7/17/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1956	
22c. NAME OF CEMETERY OR CREMATOR Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Riverdale, Md.	
24a. REC'D BY REGISTRAR July 19 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe Deputy	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07474

7553

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Valley</u> c. LENGTH OF STAY IN 1b <u>2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2409-53rd Ave</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X 3 d. STREET ADDRESS <u>314 Burbank St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Jefferson Chiles</u> First Middle Last 4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1956</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 20, 1906</u> 9. AGE (in years last birthday) <u>49</u> yrs. 10. UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u>10</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> 13. FATHER'S NAME <u>Henry Chiles</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 14. MOTHER'S MAIDEN NAME <u>Mildred</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Inez M Chiles, same as #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 10, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Williams</u> ADDRESS <u>Seneca Cr. 300-4th St. N.E.</u>			
24a. REC'D BY REGISTRAR <u>JUL 16 1956</u>		REGISTRAR'S SIGNATURE <u>Boadwin</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 16 1956
BUREAU V. 3

7500
CERTIFICATE OF DEATH

Reg. Dist. No.

074751

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4952 Annapolis Road		d. STREET ADDRESS 4952 Annapolis Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CORA AMELIA CLARKE		4. DATE OF DEATH Month Day Year 7 12 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1879
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Reamer		14. MOTHER'S MAIDEN NAME Annie Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Staley M. Clarke, 901 S. Hanley Road, St. Louis, Missouri		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHR PYELONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 6 5 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 6, 19 56 to JULY 12, 19 56 , that I last saw the deceased alive on JULY 10, 19 56 , and that death occurred at 8:10 A M, from the causes and on the date stated above. DATE SIGNED			
ACTUAL SIGNATURE Bretney Miller		M.D. 1834 Eye St NW	
PHYSICIAN'S NAME (Type) R BRETNEY MILLER			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/16/56	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR July 7, 1956	
ADDRESS 2901 14th St. N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE H. H. Hedrick	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7591

CERTIFICATE OF DEATH

07476
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Largo</u>	
c. LENGTH OF STAY IN 1b <u>22 days</u>		d. STREET ADDRESS <u>7802 Largo Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges' General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Colbert</u>		4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 April -</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Colbert</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Colbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Caroline Colbert</u>		Address <u>Farmville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemoperitoneum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforation portal vein</u> DUE TO (c) <u>Wilms Tumor - Right Kidney</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 June, 1956</u> to <u>July 12, 1956</u> , that I last saw the deceased alive on <u>July 12, 1956</u> , and that death occurred at <u>4:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Goodson</u> M.D.		ADDRESS (Street, city or town, state) <u>Prince Georges Harbor</u>	
PHYSICIAN'S NAME (Type) <u>James R. Goodson</u>		DATE SIGNED <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-16-56</u>		22b. DATE THEREOF <u>7-16-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodmore</u>		22d. LOCATION (City, town, or county) (State) <u>Woodmore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington & Sons</u>		ADDRESS <u>467 N. St.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWER	
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43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

RECEIVED
JUL 18 1956
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07478

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry 20 B.G.</u> c. LENGTH OF STAY IN 1b <u>38</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> d. STREET ADDRESS <u>5811-Sanderson Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Robert C. Cronise</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1956</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-22-76</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Butcher Food</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jonathon Rudolph Cronise</u>				14. MOTHER'S MAIDEN NAME <u>Emily Rhine</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Agnes V. Voigt</u>			
17. INFORMANT <u>Agnes V. Voigt</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gente congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u></u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7-31-56</u>					
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Saech's Sons Hyattsville Md</u>						ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>H. T. Dedrick</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AUG 5 1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

AUG 5 1956

RECEIVED

7554

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3110 Parkway Terrace Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annie S. Davis				4. DATE OF DEATH July 19, 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1878	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 9 Days 20		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME I. P. Warner				14. MOTHER'S MAIDEN NAME M. L. Pumphrey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs W. H. Whittlessey Address Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Chronic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I. Yes				INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 	
20f. (City or town) Suitland (County) Prince George (State) Md.							
21. I certify that I attended the deceased from July 18, 1956 to July 19, 1956 that I last saw the deceased alive on July 19, 1956 and that death occurred at 8:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Timothy F. O'Donovan M.D.				ADDRESS (Street, city or town, state) 4817 Homer Ave., Suitland, Md. DATE SIGNED July 19-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/56		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland ADDRESS 				24a. REC'D BY REGISTRAR July 23 1956 24b. REGISTRAR'S SIGNATURE Cassius Campbell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JUL 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

07480

2411 N. Charles Street, Baltimore

7555

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS (If rural, give location) 647 K. St., S. W.	
3. NAME OF DECEASED (Type or Print) (First) JESSIE (Middle) N (Last) DAVIS		4. DATE OF DEATH (Month) 7 (Day) 5 (Year) 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4/7/1906
9. AGE last birthday 50 yrs.		10. BIRTHPLACE (State or foreign country) Md.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ike Davis		14. MOTHER'S MAIDEN NAME Mary Kye Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 577-18-5641	
17. INFORMANT AND ADDRESS Decedent			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 162X Immediate cause (a) Bronchogenic Carcinoma Rt Lung		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 mos
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c)		
19a. DATE OF OPERATION 2		19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) SUICIDE HOMICIDE		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 2/26, 1956, to 7/5, 1956, that I last saw the deceased alive on 7/4, 1956, and that death occurred at 1:20 A. M., from the causes and on the date stated above.		
SIGNATURE Donald Lee Pinecone M. D.		DATE SIGNED 7/5/56
ADDRESS Glenn Dale Hospital Glenn Dale, Maryland		
23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE 7/6/56		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) D.C.
24. FUNERAL DIRECTOR Dr. E. J. Janssen Co. 1932-Yen St NW		ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07481

247

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE California b. COUNTY Los Angeles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ayon Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena 431-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4625 Careybrook Drive		d. STREET ADDRESS 612 Penny Slope	
3. NAME OF DECEASED (Type or print) William Marshall Dennis		4. DATE OF DEATH July 24 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1899
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper		11b. KIND OF BUSINESS OR INDUSTRY Retired	
11c. BIRTHPLACE (State or foreign country) Oregon		12. CITIZEN OF WHAT COUNTRY? U. S. &	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert L. Stark		Address same as #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Cardiovascular renal disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25-56	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.		22d. LOCATION (City, town, or county) (State) Portland Oregon	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24a. REC'D BY REGISTRAR DATE 26 1956	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

RECEIVED
JUL 26 1956
BUREAU V. S.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
RELAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

RECEIVED
JUL 26 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 335 Prince George Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna M Disney		4. DATE OF DEATH July 3, 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1874
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Laurel, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thies		14. MOTHER'S MAIDEN NAME Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Bertha Disney, Laurel, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis Chs - Coronary DUE TO occlusion (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 da 6 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/27 , 19 55 , to July 3 , 19 56 , that I last saw the deceased alive on July 2 , 19 55 , and that death occurred at 2:45 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE N B Steward M.D.		ADDRESS (Street, city or town, state) 314 Comp. Ave. Laurel DATE SIGNED 7/4/56	
PHYSICIAN'S NAME (Type) N B STEWARD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1956	
22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		22d. LOCATION (City, town, or county) (State) Muirkirk, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Carroll		24a. REC'D BY REGISTRAR July 7-56	
ADDRESS Laurel, Md.		24b. REGISTRAR'S SIGNATURE M. Boushears	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
George George		Male		35	
Place of Birth		Date of Birth		Date of Death	
Maryland		July 1, 1895		July 1, 1930	
Cause of Death		Disease		Occupation	
Heart Disease		Myocardial Infarction		Laborer	
Duration of Illness		Time of Day		Place of Death	
2 weeks		10:00 AM		Home	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		County	
July 1, 1930		Baltimore		Baltimore	

RECEIVED
JUL 12 1930
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07483

7504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Co. Hospital		d. STREET ADDRESS 5607 31st Avenue	
3. NAME OF DECEASED (Type or print) First Lawrence Middle Henry Last Dixon		4. DATE OF DEATH Month July Day 1 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1916
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Friendsville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin Dixon		14. MOTHER'S MAIDEN NAME Bertha Fike	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-12-9650	
17. INFORMANT Arnold Dixon		Address Laurel, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumatic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH one month 35 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November , 19 55 , to July , 19 56 , that I last saw the deceased alive on July 1 , 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon L. Gallin		M.D. 7306 Colesville Rd University Hills, Md	
DATE SIGNED 7/2/56			
PHYSICIAN'S NAME (Type) Leon L. Gallin			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF July 5, 1956	
22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery		22d. LOCATION (City, town, or county) (State) Friendsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Randolph		ADDRESS Laurel, Md	
24a. REC'D BY REGISTRAR DATE 5 1956		24b. REGISTRAR'S SIGNATURE R. Bodner	

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		M		35		JAN 1 1921		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		White		Brown		Blue	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
JUL 5 1956		BALTIMORE		HEART DISEASE		NATURAL		JUL 5 1956		JUL 5 1956		JUL 5 1956		JUL 5 1956	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
JUL 5 1956		BALTIMORE		HEART DISEASE		NATURAL		JUL 5 1956		JUL 5 1956		JUL 5 1956		JUL 5 1956	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

RECEIVED
JUL 5 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's 7557 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Point			c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle Joe Last Durniak				4. DATE OF DEATH Month July Day 5 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10/24	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Max Durniak				14. MOTHER'S MAIDEN NAME Mary Ozulak			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Minnie Thompson, Manassas, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Drowning Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in the river following a boat collision			
20c. TIME OF INJURY Month, Day, Year 12:15 a.m. 7/4/ 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River		20f. (City or town) (County) (State) Point P. G. M	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd M.D. EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-56		22c. NAME OF CEMETERY OR CREMATORY Manassas Cemetery		22d. LOCATION (City, town, or county) (State) Manassas Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. D. Schisler				24. REC'D BY REGISTRAR DATE 11 6 1956			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF	

BUREAU V. 1

JUL 6 1956

RECEIVED

Handwritten notes and signatures at the bottom of the page, including a date stamp "JUL 10 1956" and a signature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07485

Reg. Dist. No.

7558

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>83X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills Rd</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>304 - S. Columbus St.</u>			
3. NAME OF DECEASED (Type or print) <u>Mildred Ficklin Echols</u>				4. DATE OF DEATH <u>July 5 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18, 1886</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher of Music</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Va</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
13. FATHER'S NAME <u>Theodore H. Ficklin</u>				14. MOTHER'S MAIDEN NAME <u>Susan Carne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>2910-06111-11</u>			
17. INFORMANT <u>Mary Tallant</u>				Address <u>2910 - Old "H. St."</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma with generalized metastases</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastases</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>56</u> to <u>7/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/4</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John T. Lynn</u>				ADDRESS (Street, city or town, state) <u>5241 St Barnabas Rd SE</u>			
DATE SIGNED <u>7/5/56</u>							
PHYSICIAN'S NAME (Type) <u>JOHN T. LYNN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 9, 1956</u>		<u>Bethel Cemetery</u>		<u>Alexandria Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee's Sons Co.</u>				ADDRESS <u>300 4th St NE</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>J. W. Lee</u>			
DATE <u>JUL 9 1956</u>							

BUREAU V. S.

JUL 9 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07486

CERTIFICATE OF DEATH

7559

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>PR. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Silver Hill</u>				TOWN <u>Silver Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3222-TERRACE DR.</u>				STREET ADDRESS (If rural give location) <u>3222-Terrace DR.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Andrew</u> (Middle) <u>P.</u> (Last) <u>Egan</u>				(Month) <u>July</u> (Day) <u>19</u> (Year) <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 30-1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SIGN. COMM.</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Egnes M. Egan - 3222-Terrace DR.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10 minute	
331X IMMEDIATE CAUSE (A) <u>Cardiovascular accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic degeneration</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Essential hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1953</u> , to <u>July 19, 1956</u> , that I last saw the deceased alive on <u>7-19, 1956</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David S. Gordon</u>				ADDRESS (Street, city, town, state) <u>M.D. 5731 23rd Parkway SE, 7-1956</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>July 21-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Southland Maryland</u>	
24. REC'D BY REGISTRAR <u>23 1956</u>		REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Carrie Campbell</u>		ADDRESS <u>1661-94th Ave NE</u>	

CERTIFICATE OF DEATH

1956

1. Name of deceased: _____

2. Sex: _____

3. Race: _____

4. Date of birth: _____

5. Place of birth: _____

6. Usual residence: _____

7. Date of death: _____

8. Time of death: _____

9. Cause of death: _____

10. Place of death: _____

11. Signature of physician: _____

12. Signature of registrar: _____

13. Signature of informant: _____

14. Signature of medical examiner: _____

15. Signature of coroner: _____

16. Signature of funeral director: _____

17. Signature of undertaker: _____

18. Signature of cemetery: _____

19. Signature of burial: _____

20. Signature of interment: _____

21. Signature of cremation: _____

22. Signature of disposition: _____

23. Signature of final disposition: _____

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108. Signature of final disposition: _____

BUREAU V. 2

JUL 23 1956

RECEIVED

Carroll Campbell

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07487

CERTIFICATE OF DEATH

7505

Reg. Dist. No. 139

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN) <u>LAUREL</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LAUREL SANITARIUM</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY <u>47X-3</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WASHINGTON D.C.</u> STREET ADDRESS (If rural give location) <u>1852 Columbia Road N.W.</u>			
3. NAME OF DECEASED (Type or Print) <u>HELENA</u> (First) <u>G.</u> (Middle) <u>EVANS</u> (Last)				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>11</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 26-1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>San Francisco, California U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Everette L. Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Owen Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> (If Yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>Beverly Price Evans and Hospital Records.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>cerebral arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u> </u>							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u> M. <u> </u> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>6-8</u> , 19 <u>56</u> , to <u>7-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-11</u> , 19 <u>56</u> , and that death occurred at <u>9:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Erlon P. Macemon</u>				DATE SIGNED <u>7-11-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>7/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Sanitarium</u>		LOCATION (city, town, or county) (State) <u>Missoula, Montana</u>	
24. REC'D BY REGISTRAR <u> </u>		REGISTRAR'S SIGNATURE <u>Melie Brashers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>			

JUL 13 1956

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CHURCH

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF COFFIN MANUFACTURER

20. SIGNATURE OF CARRIER

21. SIGNATURE OF DRIVER

22. SIGNATURE OF PASSENGER

23. SIGNATURE OF ATTENDANT

24. SIGNATURE OF NURSE

25. SIGNATURE OF CHAPLAIN

26. SIGNATURE OF MINISTER

27. SIGNATURE OF RABBI

28. SIGNATURE OF PRIEST

29. SIGNATURE OF BISHOP

30. SIGNATURE OF ARCHBISHOP

31. SIGNATURE OF CARDINAL

32. SIGNATURE OF POPE

33. SIGNATURE OF DECEASED

34. SIGNATURE OF NEXT OF KIN

35. SIGNATURE OF BURIAL SOCIETY

36. SIGNATURE OF CHURCH

37. SIGNATURE OF CEMETERY

38. SIGNATURE OF FUNERAL HOME

39. SIGNATURE OF COFFIN MANUFACTURER

40. SIGNATURE OF CARRIER

41. SIGNATURE OF DRIVER

42. SIGNATURE OF PASSENGER

43. SIGNATURE OF ATTENDANT

44. SIGNATURE OF NURSE

45. SIGNATURE OF CHAPLAIN

46. SIGNATURE OF MINISTER

47. SIGNATURE OF RABBI

48. SIGNATURE OF PRIEST

49. SIGNATURE OF BISHOP

50. SIGNATURE OF ARCHBISHOP

51. SIGNATURE OF CARDINAL

52. SIGNATURE OF POPE

53. SIGNATURE OF DECEASED

54. SIGNATURE OF NEXT OF KIN

55. SIGNATURE OF BURIAL SOCIETY

56. SIGNATURE OF CHURCH

57. SIGNATURE OF CEMETERY

58. SIGNATURE OF FUNERAL HOME

59. SIGNATURE OF COFFIN MANUFACTURER

60. SIGNATURE OF CARRIER

61. SIGNATURE OF DRIVER

62. SIGNATURE OF PASSENGER

63. SIGNATURE OF ATTENDANT

64. SIGNATURE OF NURSE

65. SIGNATURE OF CHAPLAIN

66. SIGNATURE OF MINISTER

67. SIGNATURE OF RABBI

68. SIGNATURE OF PRIEST

69. SIGNATURE OF BISHOP

70. SIGNATURE OF ARCHBISHOP

71. SIGNATURE OF CARDINAL

72. SIGNATURE OF POPE

73. SIGNATURE OF DECEASED

74. SIGNATURE OF NEXT OF KIN

75. SIGNATURE OF BURIAL SOCIETY

76. SIGNATURE OF CHURCH

77. SIGNATURE OF CEMETERY

78. SIGNATURE OF FUNERAL HOME

79. SIGNATURE OF COFFIN MANUFACTURER

80. SIGNATURE OF CARRIER

81. SIGNATURE OF DRIVER

82. SIGNATURE OF PASSENGER

83. SIGNATURE OF ATTENDANT

84. SIGNATURE OF NURSE

85. SIGNATURE OF CHAPLAIN

86. SIGNATURE OF MINISTER

87. SIGNATURE OF RABBI

88. SIGNATURE OF PRIEST

89. SIGNATURE OF BISHOP

90. SIGNATURE OF ARCHBISHOP

91. SIGNATURE OF CARDINAL

92. SIGNATURE OF POPE

93. SIGNATURE OF DECEASED

94. SIGNATURE OF NEXT OF KIN

95. SIGNATURE OF BURIAL SOCIETY

96. SIGNATURE OF CHURCH

97. SIGNATURE OF CEMETERY

98. SIGNATURE OF FUNERAL HOME

99. SIGNATURE OF COFFIN MANUFACTURER

100. SIGNATURE OF CARRIER

101. SIGNATURE OF DRIVER

102. SIGNATURE OF PASSENGER

103. SIGNATURE OF ATTENDANT

104. SIGNATURE OF NURSE

105. SIGNATURE OF CHAPLAIN

106. SIGNATURE OF MINISTER

107. SIGNATURE OF RABBI

108. SIGNATURE OF PRIEST

109. SIGNATURE OF BISHOP

110. SIGNATURE OF ARCHBISHOP

111. SIGNATURE OF CARDINAL

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232. SIGNATURE OF POPE

233. SIGNATURE OF DECEASED

234. SIGNATURE OF NEXT OF KIN

235. SIGNATURE OF BURIAL SOCIETY

236. SIGNATURE OF CHURCH

237. SIGNATURE OF CEMETERY

238. SIGNATURE OF FUNERAL HOME

239. SIGNATURE OF COFFIN MANUFACTURER

240. SIGNATURE OF CARRIER

241. SIGNATURE OF DRIVER

242. SIGNATURE OF PASSENGER

243. SIGNATURE OF ATTENDANT

244. SIGNATURE OF NURSE

245. SIGNATURE OF CHAPLAIN

246. SIGNATURE OF MINISTER

247. SIGNATURE OF RABBI

248. SIGNATURE OF PRIEST

249. SIGNATURE OF BISHOP

250. SIGNATURE OF ARCHBISHOP

251. SIGNATURE OF CARDINAL

252. SIGNATURE OF POPE

253. SIGNATURE OF DECEASED

254. SIGNATURE OF NEXT OF KIN

255. SIGNATURE OF BURIAL SOCIETY

7481

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md c. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home				d. STREET ADDRESS 4612 Amburst Rd			
3. NAME OF DECEASED (Type or print) JOHN First E. Middle FABER Last				4. DATE OF DEATH July 26, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 7 - 1876	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker				10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory			
11. BIRTHPLACE (State or foreign country) Penna				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Samuel Faber				14. MOTHER'S MAIDEN NAME Anna Beck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 1898-1898				16. SOCIAL SECURITY NO.			
17. INFORMANT Anna Parker Faber				Address College Park Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 weeks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 7:25, 1956 to 7:26, 1956, that I last saw the deceased alive on 7:25, 1956, and that death occurred at 2 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jules B Edlow				ADDRESS (Street, city or town, state) Greenbelt Md			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/30/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE F Busch Sons Hyattsville Md				24a. REC'D BY REGISTRAR DATE JUL 27 1956		24b. REGISTRAR'S SIGNATURE Jas. L. Jones	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 10

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1910		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		DATE OF MARRIAGE 1935		NAME OF SPOUSE Mary H. Harris		DATE OF DEATH July 27, 1956		PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Heart Disease	
OCCUPATION Salesman		EDUCATION High School		RELIGION Roman Catholic		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF SPOUSE Mary H. Harris		SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF CORONER John D. Jones		SIGNATURE OF REGISTRAR Jane K. Doe		SIGNATURE OF WITNESS John A. Brown	
DATE OF SIGNATURE July 27, 1956		DATE OF SIGNATURE July 27, 1956		DATE OF SIGNATURE July 27, 1956		DATE OF SIGNATURE July 27, 1956		DATE OF SIGNATURE July 27, 1956		DATE OF SIGNATURE July 27, 1956	

BUREAU Y. 2

JUL 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07489

Reg. Dist. No.

7506

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lestrict Heights</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>7700 Alpine Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>7</u> Last <u>Terence</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1930</u>
9. AGE (In years last birthday) <u>26 yrs.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working years, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Communications</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Dean Terence</u>		14. MOTHER'S MAIDEN NAME <u>Susie Lemoneck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>196-22-0871</u>	
17. INFORMANT <u>Harley Lee, Washington, D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cranial hemorrhage</u> 824X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of base of skull</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was standing on bumper of car and fell to ground</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-13-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Street</u>		20f. (City or town) <u>Lestrict Heights</u> (County) <u>Prince Georges</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/20/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		ADDRESS <u>517 11th St N.E.</u>	
24a. REC'D BY REGISTRAR <u>July 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, cremation or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 20 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 221

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>11409 Edmonston Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>Fields</u> Last <u>Fields</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 Jan 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Lanul Maryland U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Benjamin Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Sumner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Sadie Johnson</u>		Address <u>11409 Edmonston Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transitional Cell Carcinoma of</u> <u>181X</u> DUE TO <u>Bladder with Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 17, 1956</u> to <u>July 24, 1956</u> , that I last saw the deceased alive on <u>July 24, 1956</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon L. Gellier</u>		ADDRESS (Street, city or town, state) <u>7206 Cokerville Rd</u>	
PHYSICIAN'S NAME (Type) <u>W. Hyatt Wells, Md.</u>		DATE SIGNED <u>7/25/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>7-27-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bacon Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington + Sons</u>		ADDRESS <u>467 N St. N.W.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>R.D. March</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES E. SMITH		Male		45		White		1910		Maryland		1955		Baltimore		Heart Disease		Natural		J. E. Smith		J. E. Smith	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Teacher		High School		Married		Catholic		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith	

BUREAU V. 2

MIG 1 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 FilmG200 7-24-56 et

07491

7560

CERTIFICATE OF DEATH

Reg. Dist. No. *46*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Aquasco</i>		<i>Lifetime</i>		TOWN <i>Aquasco</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>GEORGE FRANCIS FORBES</i> (Middle) (Last)				(Month) <i>July</i> (Day) <i>17</i> (Year) <i>19 56</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>April 15, 1880</i>	<i>76 7/8</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Farmer</i>		<i>Farm</i>		<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>George Forbes</i>				<i>Fanny Bowling</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>X</i>		<i>W. G. F. Forbes - Aquasco Md</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<i>1 week</i>	
151X IMMEDIATE CAUSE (A) <i>Insanitation</i>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Adeno-Carcinoma of Stomach</i>						<i>at least 1 yr.</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Chronic Valvular Disease</i>						<i>at least 2 yr.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY?	
<i>Jan 4, 1955</i>		<i>Massive Stomach Carcinoma</i>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY-street, office-bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 13, 1955</i> to <i>July 17, 1956</i> , that I last saw the deceased alive on <i>July 17, 1956</i> , and that death occurred at <i>5:20 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Wahab M. Seron</i>				ADDRESS (Street, city, town, state) <i>Aquasco Md</i>		DATE SIGNED <i>7/17/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Cremation</i>		<i>7/19/56</i>		<i>St. Dominic</i>		<i>Aquasco Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>JUL 20 1956</i>		<i>John F. Dancy</i>		<i>The Hunt Funeral Home</i>		<i>md</i>	

CERTIFICATE OF DEATH

Form No. 1

For use in the State of Maryland

1. Name of deceased: _____
 2. Sex: _____
 3. Age: _____
 4. Date of birth: _____
 5. Place of birth: _____
 6. Date of death: _____
 7. Place of death: _____
 8. Cause of death: _____
 9. Manner of death: _____
 10. Signature of physician: _____
 11. Signature of registrar: _____
 12. Date of registration: _____

13. Name of informant: _____
 14. Address of informant: _____
 15. Signature of informant: _____

BUREAU V. S.

JUL 20 1956

RECEIVED

John J. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7482
CERTIFICATE OF DEATH

07492
245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4109 CLAGETT RD</u>				d. STREET ADDRESS <u>4109 Clagett Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Freeman Ellsworth Foy</u>				4. DATE OF DEATH <u>July 14 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 3 1865</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LEON ILLINOIS</u>		11. BIRTHPLACE (State or foreign country) <u>ALSA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>ALSA</u>							
13. FATHER'S NAME <u>George Foy</u>				14. MOTHER'S MAIDEN NAME <u>NANCY P. DICKENSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MAUDE HEIN</u> Address <u>daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 years</u> (c) <u>10 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 9, 1956</u> to <u>July 14, 1956</u> ; that I last saw the deceased alive on <u>July 9, 1956</u> and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Borneau</u>		ADDRESS (Street, city or town, state) <u>3503 Betty St Mt Rainier Md</u>		DATE SIGNED <u>7/14/56</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BORNEAU</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>7/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tampico</u>		22d. LOCATION (City, town, or county) (State) <u>Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>JUL 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>James E. Sweeney</u>	

BUREAU V. S.

1956 16 70

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7483 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0749345

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 13 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3005 Kennedy Street				d. STREET ADDRESS 4005 Kennedy Street					
3. NAME OF DECEASED (Type or print) First Middle Last Bernard James Gallagher				4. DATE OF DEATH Month Day Year July 15 19 56					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1984			
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired plumber		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James B. Gallagher				14. MOTHER'S MAIDEN NAME Mary E. Donahue					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Eugene A. Gallagher, Same address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		July 15th, 1956			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1956		22c. NAME OF CEMETERY OR CREMATORY St Mary's Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE July 19, 1956		24b. REGISTRAR'S SIGNATURE Jas. Karp			

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF NURSE		18. SIGNATURE OF CHAPLAIN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF OTHER	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF		25. SIGNATURE OF JURY	
26. SIGNATURE OF DISTRICT ATTORNEY		27. SIGNATURE OF COUNTY CLERK		28. SIGNATURE OF TOWNSHIP CLERK		29. SIGNATURE OF VILLAGE CLERK		30. SIGNATURE OF CITY CLERK	
31. SIGNATURE OF MAYOR		32. SIGNATURE OF COMMISSIONER		33. SIGNATURE OF BOARD OF HEALTH		34. SIGNATURE OF BOARD OF CHARITY		35. SIGNATURE OF BOARD OF EDUCATION	
36. SIGNATURE OF BOARD OF TRADE		37. SIGNATURE OF BOARD OF AGRICULTURE		38. SIGNATURE OF BOARD OF COMMERCE		39. SIGNATURE OF BOARD OF MINES		40. SIGNATURE OF BOARD OF PUBLIC WORKS	
41. SIGNATURE OF BOARD OF FIRE		42. SIGNATURE OF BOARD OF FIRE INSURANCE		43. SIGNATURE OF BOARD OF FIRE MARSHAL		44. SIGNATURE OF BOARD OF FIRE ENGINEER		45. SIGNATURE OF BOARD OF FIRE FIGHTER	
46. SIGNATURE OF BOARD OF FIRE ALARM		47. SIGNATURE OF BOARD OF FIRE LADDER		48. SIGNATURE OF BOARD OF FIRE PUMP		49. SIGNATURE OF BOARD OF FIRE TRUCK		50. SIGNATURE OF BOARD OF FIRE TOWER	
51. SIGNATURE OF BOARD OF FIRE STATION		52. SIGNATURE OF BOARD OF FIRE HOUSE		53. SIGNATURE OF BOARD OF FIRE GARAGE		54. SIGNATURE OF BOARD OF FIRE SHED		55. SIGNATURE OF BOARD OF FIRE BARN	
56. SIGNATURE OF BOARD OF FIRE MILL		57. SIGNATURE OF BOARD OF FIRE FACTORY		58. SIGNATURE OF BOARD OF FIRE WHARF		59. SIGNATURE OF BOARD OF FIRE DOCK		60. SIGNATURE OF BOARD OF FIRE PIER	
61. SIGNATURE OF BOARD OF FIRE BRIDGE		62. SIGNATURE OF BOARD OF FIRE TUNNEL		63. SIGNATURE OF BOARD OF FIRE CAUSEWAY		64. SIGNATURE OF BOARD OF FIRE FERRY		65. SIGNATURE OF BOARD OF FIRE BOAT	
66. SIGNATURE OF BOARD OF FIRE SHIP		67. SIGNATURE OF BOARD OF FIRE VESSEL		68. SIGNATURE OF BOARD OF FIRE CRAFT		69. SIGNATURE OF BOARD OF FIRE MACHINERY		70. SIGNATURE OF BOARD OF FIRE EQUIPMENT	
71. SIGNATURE OF BOARD OF FIRE TOOLS		72. SIGNATURE OF BOARD OF FIRE MATERIALS		73. SIGNATURE OF BOARD OF FIRE SUPPLIES		74. SIGNATURE OF BOARD OF FIRE SERVICES		75. SIGNATURE OF BOARD OF FIRE CONTRACTORS	
76. SIGNATURE OF BOARD OF FIRE LABORERS		77. SIGNATURE OF BOARD OF FIRE EMPLOYEES		78. SIGNATURE OF BOARD OF FIRE UNIONS		79. SIGNATURE OF BOARD OF FIRE ASSOCIATIONS		80. SIGNATURE OF BOARD OF FIRE SOCIETIES	
81. SIGNATURE OF BOARD OF FIRE CLUBS		82. SIGNATURE OF BOARD OF FIRE LIGUES		83. SIGNATURE OF BOARD OF FIRE ORDERS		84. SIGNATURE OF BOARD OF FIRE COMPANIES		85. SIGNATURE OF BOARD OF FIRE SOCIETIES	
86. SIGNATURE OF BOARD OF FIRE INSTITUTIONS		87. SIGNATURE OF BOARD OF FIRE FOUNDATIONS		88. SIGNATURE OF BOARD OF FIRE ENDOWMENTS		89. SIGNATURE OF BOARD OF FIRE TRUSTS		90. SIGNATURE OF BOARD OF FIRE ESTATES	
91. SIGNATURE OF BOARD OF FIRE CHARITIES		92. SIGNATURE OF BOARD OF FIRE RELIGIOUS		93. SIGNATURE OF BOARD OF FIRE EDUCATIONAL		94. SIGNATURE OF BOARD OF FIRE SCIENTIFIC		95. SIGNATURE OF BOARD OF FIRE ARTS	
96. SIGNATURE OF BOARD OF FIRE LITERARY		97. SIGNATURE OF BOARD OF FIRE PHILOSOPHICAL		98. SIGNATURE OF BOARD OF FIRE HISTORICAL		99. SIGNATURE OF BOARD OF FIRE GEOGRAPHICAL		100. SIGNATURE OF BOARD OF FIRE ZOOLOGICAL	
101. SIGNATURE OF BOARD OF FIRE BOTANICAL		102. SIGNATURE OF BOARD OF FIRE MINERALOGICAL		103. SIGNATURE OF BOARD OF FIRE METEOROLOGICAL		104. SIGNATURE OF BOARD OF FIRE ASTRONOMICAL		105. SIGNATURE OF BOARD OF FIRE PHYSICAL	
106. SIGNATURE OF BOARD OF FIRE MATHEMATICAL		107. SIGNATURE OF BOARD OF FIRE MEDICAL		108. SIGNATURE OF BOARD OF FIRE LEGAL		109. SIGNATURE OF BOARD OF FIRE POLITICAL		110. SIGNATURE OF BOARD OF FIRE ECONOMIC	
111. SIGNATURE OF BOARD OF FIRE SOCIAL		112. SIGNATURE OF BOARD OF FIRE PSYCHOLOGICAL		113. SIGNATURE OF BOARD OF FIRE PEDAGOGICAL		114. SIGNATURE OF BOARD OF FIRE PEDAGOGICAL		115. SIGNATURE OF BOARD OF FIRE PEDAGOGICAL	
116. SIGNATURE OF BOARD OF FIRE PEDAGOGICAL		117. SIGNATURE OF BOARD OF FIRE PEDAGOGICAL		118. SIGNATURE OF BOARD OF FIRE PEDAGOGICAL		119. SIGNATURE OF BOARD OF FIRE PEDAGOGICAL		120. SIGNATURE OF BOARD OF FIRE PEDAGOGICAL	

RECEIVED
JUL 19 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7508

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 4819 Rutan Street	
3. NAME OF DECEASED (Type or print) First Middle Last Edward JOSEPH Goodwin		4. DATE OF DEATH Month 7 Day 1 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-22-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER GOVERNMENT		9. AGE (In years lost by child) 64 yrs.	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME WILLIAM GOODWIN		14. MOTHER'S MAIDEN NAME CATARRINE MERRIMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Statistic Card		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Coronary Thrombosis with Myocardial Infarction DUE TO (b) Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-15, 1956, to 7-1, 1956, that I last saw the deceased alive on 7-1, 1956, and that death occurred at 10:25 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE W. L. ETIENNE		ADDRESS (Street, city or town, state) 4713 - Morningside College Park, Md. (7-1-56)	
PHYSICIAN'S NAME (Type) W. L. ETIENNE		DATE SIGNED 7-1-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/3/1956	22c. NAME OF CEMETERY OR CREMATORY Wash. Natl. Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		24. REG'D BY REGISTRAR	
O. W. Chambers		Riversdale Md.	

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RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

232

7562

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro Summit</u>		c. LENGTH OF STAY IN 1b <u>College Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 4</u>		d. STREET ADDRESS <u>5002 Cree Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Franklin</u> Last <u>Gravelly</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1898</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>George D. Gravelly</u>		14. MOTHER'S MARDEN NAME <u>Annie Belle Milburn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Matillion Gravelly, same as #2</u>	
17. INFORMANT <u>Matillion Gravelly, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiorenal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 30, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, town or county) (State) <u>Hyattsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph's Sons Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 3 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>John F. Danvers</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 3 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07497

7563

CERTIFICATE OF DEATH

Reg. Dist. No.

747

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PR. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Run Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Run Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>2203 Afton ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Guzick</u> Last <u>Guzick</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 55</u>
9. AGE (In years last birthday) yrs. <u>8</u> Months <u>13</u> Days <u>13</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lawrence Guzick</u>		14. MOTHER'S MAIDEN NAME <u>Ursula Huber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Ursula Guzick</u>		Address <u>2203 Afton ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>355x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Convulsive Disorder</u> DUE TO (c) <u>Cerebral Atrophy - Right side</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 mos</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 6, 1955</u> to <u>July 22, 1958</u> , that I last saw the deceased alive on <u>July 23, 1956</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Schmitz</u> M.D.		ADDRESS (Street, city or town, state) <u>2220 Forest Rd, Hyattsville, Md</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>7-23-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE	

BUREAU V. S.

JUL 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7509

CERTIFICATE OF DEATH

07498

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>	c. LENGTH OF STAY IN 1b <u>8 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>7219 Central Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Joseph</u> Last <u>Hamilton</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1909</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. UNDER 1 YEAR Months <u>17</u> Days <u>11</u>	11. UNDER 24 HRS. Hours <u>12</u> Min. <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Tobacco)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William E. Hamilton</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Boswell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Catherine Hamilton</u>		Address <u>7219 Central Ave., Seat Pleasant, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>583X</u> DUE TO <u>Hepatic arterio gastritis with profuse bleeding</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hepatitis</u> DUE TO (c) <u>Hepatitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>renal</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 22, 1956</u> to <u>July 29, 1956</u> , that I last saw the deceased alive on <u>July 29, 1956</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George H. McLean</u> M.D.		ADDRESS (Street, city or town, state) <u>1746 K St. N.W. Wash - D.C.</u> DATE SIGNED <u>July 30, 1956</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nettie Boswell</u>		ADDRESS <u>Upper Marlboro, Md.</u>	24a. REC'D BY REGISTRAR <u>DATE 8-1-56</u>
		24b. REGISTRAR'S SIGNATURE <u>O.P. March</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1920		MOBILE, ALABAMA		MOBILE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
AUG 6 1968		MOBILE, ALABAMA		MOBILE		UNITED STATES		AUG 6 1968		MOBILE, ALABAMA		MOBILE		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
AUG 6 1968		MOBILE, ALABAMA		MOBILE		UNITED STATES		AUG 6 1968		MOBILE, ALABAMA		MOBILE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
AUG 6 1968		MOBILE, ALABAMA		MOBILE		UNITED STATES		AUG 6 1968		MOBILE, ALABAMA		MOBILE		UNITED STATES	

BUREAU V. 2

AUG 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07499

Reg. Dist. No.

7510

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u>				d. STREET ADDRESS <u>5504 Newton Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Stephanie</u> Middle <u>Lee</u> Last <u>Harding</u>				4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. B. DATE OF BIRTH <u>5-9-56</u>		9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>7</u> weeks			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Robert Alexander Harding</u>			
14. MOTHER'S MAIDEN NAME <u>Patricia Lee Byers</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mother-- Same address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema of the chest.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>July 1, 1956</u>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glennwood</u>			
22d. LOCATION (City, town, or county) <u>Washington St.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Saffell</u>		ADDRESS <u>475 A street N.W.</u>		24a. REC'D BY REGISTRAR <u>8/1/56</u>			
24b. REGISTRAR'S SIGNATURE <u>W. Church</u>		DATE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 3 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meadows</u> c. LENGTH OF STAY IN 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marlboro Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meadows</u> d. STREET ADDRESS <u>Marlboro Pike</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Harmon</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1956</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1871</u>		9. AGE (If years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-16 9438</u>		17. INFORMANT <u>Helen Greenfield, same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James L. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>July 8, 1956</u>			
EXAMINER'S NAME (Type) <u>James L. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/11/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland R. Co. Co., MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamberlaine</u>				ADDRESS <u>517-119555, WIND</u>		24a. REC'D. BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>L. H. Hedrick</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 11 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7484

CERTIFICATE OF DEATH

Reg. Dist. No.

07501

245

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1912 Erie St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Rodney</u> Middle <u>William</u> Last <u>Hawkins</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1909</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arnold Austin Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Zenobia Rider</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>21410 8138</u>		17. INFORMANT Address <u>1912 Erie St. West Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>6 years</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 1955</u> to <u>July 28, 1956</u> , that I last saw the deceased alive on <u>July 28, 1956</u> , and that death occurred at <u>10:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James F. Laubach</u> M.D.				ADDRESS (Street, city or town, state) <u>1806 Fox St. Hyattsville, Md.</u>			
DATE SIGNED <u>7/28/56</u>							
PHYSICIAN'S NAME (Type) <u>JAMES L. LAUBACH, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee, Son</u> ADDRESS <u>Wash. D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 2 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severn</u> Deputy	

Primer George
 Westhoffville 1901
 1915 Erie St.
 Madison
 Westhoffville

Robert William Howard
 June 1884
 25 25

Bookkeeper
 Restaurant Madison
 1915
 Arnold Austin Howard
 2000 Erie St.
 Madison

Victorian Fabrication
 Atomic Scientific Heat Discs
 1900

X

James L. Larcher, M.D.
 1901-1902
 10:40
 25 25
 1901-1902
 10:40
 25 25

RECEIVED
 JUNE 3 1956
 BUREAU V. 2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07502

7488 CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Prince Georges		MARYLAND		STATE Md.		COUNTY Pr. Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Rainier		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Rainier			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3214 Chillum Road				STREET ADDRESS (If rural give location) 3214 Chillum Road			
3. NAME OF DECEASED (First) Earl (Middle) E. (Last) Hindman				4. DATE OF DEATH (Month) July (Day) 28 (Year) 1956			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, widowed	8. DATE OF BIRTH 3/16/1888	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, U.S. Govt. P.O.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ripley, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm. H. Hindman				14. MOTHER'S MAIDEN NAME Mary Virginia Fagan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. - -		17. INFORMANT & ADDRESS LeRoy Hindman, Brother			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis, Acute						INTERVAL BETWEEN ONSET AND DEATH instant	
ANTECEDENT CAUSE(S) DUE TO Coronary Heart Disease						2 1/2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO Arteriosclerosis, generalized						21 approx.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from September 26, 1953, 19....., that I last saw the deceased alive on June 8, 1958, and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
SIGNATURE Samuel A. Hillman M.D.		DATE SIGNED ADDRESS (Street, city, town, state) 249 Missouri Avenue N.W.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/31/1956		NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		LOCATION (City, town, or county) (State) Prince Georges Co., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mrs. Jas. Severel		25. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Wash, D.C.			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	

BUREAU V. S.

AUG 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7511

CERTIFICATE OF DEATH

07503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital		d. STREET ADDRESS 5102 42th avenue,.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Howard Hiram Holmes		4. DATE OF DEATH Month Day Year July 18, 1956.	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 27, 1897
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hyattsville Police Dept		10b. KIND OF BUSINESS OR INDUSTRY Chief	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Hohn Holmes		14. MOTHER'S MAIDEN NAME Estelle Kimbel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Edythe Holmes		Address Hyattsville, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April, 1956, to July 11, 1956, that I last saw the deceased alive on July 11, 1956, and that death occurred at 1 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Anola Q Lear MD		ADDRESS (Street, city or town, state) 4314 Gallatin St. Hyattsville Md	
DATE SIGNED 7/19/56			
PHYSICIAN'S NAME (Type) A. A. LEAR MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/56	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE 23 1956	
24b. REGISTRAR'S SIGNATURE A. H. Harkins			

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7512
CERTIFICATE OF DEATH

07504
231

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Prince Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chrenesly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen Hosp			d. STREET ADDRESS 4319 Gallatin St.		
3. NAME OF DECEASED (Type or print) Edyth Hughes			4. DATE OF DEATH July 11 1956		
5. SEX F		6. COLOR OF RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-10-77		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY self		
11. BIRTHPLACE (State or foreign country) Nebraska			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George Lewis			14. MOTHER'S MAIDEN NAME Sarah H. Wheeler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. None		
17. INFORMANT Geo Van Camp			Address Hyattsville Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephro-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 5-30, 1956, to 7-11, 1956, that I last saw the deceased alive on 7-11, 1956, and that death occurred at 11:35 PM, from the causes and on the date stated above.					
ACTUAL SIGNATURE William Brainin M.D.			ADDRESS (Street, city or town, state) 6124 Central Ave		
PHYSICIAN'S NAME (Type) William BRAININ			DATE SIGNED 7/12/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Colmar Manor Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.		
24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE		

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		M		45		W		JAN 15 1911		BALTIMORE, MD.		JUL 10 1956		BALTIMORE, MD.		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF REGISTRAR		15. FULL NAME OF WITNESS		16. FULL NAME OF WITNESS		17. FULL NAME OF WITNESS		18. FULL NAME OF WITNESS		19. FULL NAME OF WITNESS		20. FULL NAME OF WITNESS		21. FULL NAME OF WITNESS		22. FULL NAME OF WITNESS		23. FULL NAME OF WITNESS		24. FULL NAME OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

JUL 16 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7513 CERTIFICATE OF DEATH

07505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naylor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen. Hospital</u>				d. STREET ADDRESS <u>Rt 81</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Jackson</u>			4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 June 1956</u>		9. AGE (In years lost birthday) yrs. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Prince Geo. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William O. Conates</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte L. Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Charlotte L. Jackson</u>		Address <u>Naylor, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 26, 1956</u> to <u>July 8, 1956</u> , that I last saw the deceased alive on <u>July 26, 1956</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Pukin</u>				M.D. <u>5301 Hamilton St. Hyattsville</u>			
PHYSICIAN'S NAME (Type) <u>Huntt</u>				DATE SIGNED <u>7/8/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooks</u>		22d. LOCATION (City, town, or county) (State) <u>Naylor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt</u> ADDRESS <u>Waldorf Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. French</u>	

2077202XV3

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>New York City</i>		6. RACE <i>White</i>	
7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF MARRIAGE <i>Jan 15 1935</i>	
10. DATE OF DEATH <i>Jan 15 1956</i>		11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. S.

UL 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07506

Reg. Dist. No. 243

7565

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Coleman's Farm				d. STREET ADDRESS Church Road			
3. NAME OF DECEASED (Type or print) First Emory Middle Johnson, Jr. Last				4. DATE OF DEATH Month July Day 9th Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH March 1, 1941			
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolboy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Emory Johnson, Sr.			
14. MOTHER'S MAIDEN NAME Mary Magdalen Butler				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Father, Same address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution by lightning DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) The boy had taken shelter under a tree. Tree and boy were struck by lightning.					
20c. TIME OF INJURY Month, Day, Year 5:00 P.M. 7-9- 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm			
20f. (City or town) Mitchellville, Pr. Geo. Md.		20g. (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i>		EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED July 9, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-56		22c. NAME OF CEMETERY OR CREMATORY Church Cemetery			
22d. LOCATION (City, town, or county) La Plata, Md.		22e. (State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S.W.			24a. REC'D BY REGISTRAR DATE 12-19-56				
24b. REGISTRAR'S SIGNATURE <i>Mrs. John Youngling</i>			24c. (City or town) La Plata, Md.				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records prior to burial, cremation, or removal.

KENTUCKY STATE DEPARTMENT OF HEALTH - SALTFORD 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 12 1956
RIDEAU W. S.

15700341202

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7514

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07507

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Estelle</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-27</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John D. Carney</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Husband; same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Status asmaticus</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) <u>Arlington Va.</u>				(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>			
24. REC'D BY REGISTRAR <u> </u>				24b. REGISTRAR'S SIGNATURE <u> </u>			
DATE <u> </u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2.

JUL 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7566 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>	
c. LENGTH OF STAY IN 1b <u>84 years</u>		d. STREET ADDRESS <u>1514-51st Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Frank Leonard Kemper</u>			4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1956</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-84</u>	9. AGE (in years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>New Albany, Ind.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. &</u>
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13. FATHER'S NAME <u>James Kemper</u>	14. MOTHER'S MAIDEN NAME <u>Mary Harding</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>1-2-25-84</u>	17. INFORMANT <u>Theresa A. Kemper, same as 12</u>	Address <u>same as 12</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>Cardiovascular renal disease</u> DUE TO <u>Cardiovascular renal disease</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE <u>James I. Boyd</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>7-5-56</u>
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-9-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysong</u>	ADDRESS <u>1300 N St. NW Washington DC</u>	24a. REC'D BY REGISTRAR <u>W. B. Hysong</u>	24b. REGISTRAR'S SIGNATURE <u>W. B. Hysong</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

RECEIVED
JUL 9 1956
BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07509

7567

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hill Crest Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hill Crest Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 5318 26th Ave	
3. NAME OF DECEASED (Type or print) SABINO First Middle Last		4. DATE OF DEATH July 5 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George Kosko - 5318-26th St. N.E.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive Cardio-vascular Disease DUE TO (c) vascular Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/30, 1956, to 7/5, 1956, that I last saw the deceased alive on 6/30, 1956, and that death occurred at 9 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David Hernandez		ADDRESS (Street, city or town, state) 2901 Fairlawn St. S.E.	
PHYSICIAN'S NAME (Type) David Hernandez		DATE SIGNED 7/5/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9, 1956	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sons		23c. NAME OF CEMETERY OR CREMATORY Wash. D.C. Mt. Manassas	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE 6/19/56			

1956 9 JUL

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10593

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hgts.</u>			
c. LENGTH OF STAY IN 1b <u>7 days</u>				d. STREET ADDRESS <u>6228 Lee Place</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Latimore</u>				4. DATE OF DEATH <u>July 4 1956</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Proctor James Walter</u>				14. MOTHER'S MAIDEN NAME <u>Latimore Annie Beatrice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/27/1956</u> to <u>7/4/1956</u> , that I last saw the deceased alive on <u>7/4/1956</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u> M.D. <u>5301 Hamlet St.</u> DATE SIGNED <u>7/5/56</u>				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Original</u>		<u>Oct 1956</u>		<u>Prince Georges Gen Hosp</u>		<u>Chesley Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Perkins</u> ADDRESS <u>Adrian</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 22 '56</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

2077212XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

OCT 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 3: MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Film G200 8/2/56 dmr. 7515 CERTIFICATE OF DEATH

Reg. Dist. No.

07510

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>48 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 15		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>			d. STREET ADDRESS <u>4108 Jefferson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>E.</u> Last <u>Latimer</u>			4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-?-1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Doctor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James B. Latimer</u>			14. MOTHER'S MARDEN NAME <u>Mary Sedwick</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Statistic Card</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF STOMACH</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>56</u> , to <u>7/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/20</u> , 19 <u>56</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Norman Donat Comeau</u>		M.D. <u>3503 Perry St. Mt. Rainier Md.</u>		DATE SIGNED <u>7/20/56</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>7/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Guscha</u>		ADDRESS <u>sons Hyattsville, Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Sedwick</u>	

BUREAU V. S.

JUL 24 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

7568

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park		c. LENGTH OF STAY IN lb 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1414 University Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Estelle Leeland		4. DATE OF DEATH Month Day Year July 31, 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, '30
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dominice Grove		14. MOTHER'S MAIDEN NAME Estelle Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Eugene W. Leeland Husband, Same address.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of head DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound.	
20c. TIME OF INJURY Month, Day, Year Hour IX 12:30 p.m. 7-31- 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Langley Park, Pr. Geo. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 31, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Hutton		24a. REC'D BY REGISTRAR AUG 5	
		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STREAN

1956 5 AUG

RECEIVED

Item 20, Film G201 8-17-56 ans
Items 8, 15: G201 8-20-56L

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 10 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.				d. STREET ADDRESS 8505 Cunningham Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Joseph Last Leyh				4. DATE OF DEATH Month July Day 12 Year 1956			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1928		9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months 27 Days 27	IF UNDER 24 HRS. Hours 27 Min. 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Signalman		10b. KIND OF BUSINESS OR INDUSTRY Washington terminal		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence D. Leyh				14. MOTHER'S MAIDEN NAME Ruth Hamilton Kestler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1956-434 11/50-52		17. INFORMANT Ruth Hamilton Leyh, Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral compression (c) Subdural hemorrhage and concussion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of automobile. Hit a culvert & turned over 6 or 8 times					
20c. TIME OF INJURY Hour 1:30 o. m. 7-12-1956 p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Govt Farms-Powder Mill Rd. Berwyn Hts. P. Geo. Md		20f. (City or town) Hyattsville, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 12, 1956			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 16, 1956	22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) Hyattsville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24. REG'D BY REGISTRAR Jul 13 1956		24b. REGISTRAR'S SIGNATURE J. B. Carich	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registration number should be retained for your files. The pages 1 and 2 with the registration number should be used as a burial-transit permit. The pages 1 and 2 with the registration number should be used as a burial-transit permit.

BUREAU V. 31

JUL 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07513

7569

CERTIFICATE OF DEATH

Reg. Dist. No. 243

Item 7, Film G200 7-13-56 et

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY <u>47X-3</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Hospital</u>		STREET ADDRESS (If rural, give location) <u>615 - 6th Street, S.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Clarence</u> (First) <u>(NMI)</u> (Middle) <u>Ludlam</u> (Last)		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/22/1884</u>
9. AGE last birthday <u>72</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. COUNTRY OF WHAT CITIZEN? <u>USA</u>	
13. FATHER'S NAME <u>George R. Ludlam</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>606X</u> <u>uremia due to</u>		<u>2 days</u>
Antecedent cause(s) (b) <u>Chronic cystopyelonephritis</u>		<u>15 months</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>002X</u> <u>Inverticulum of the urinary bladder</u>		<u>15 months</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary Tuberculosis</u>		<u>27 yrs 5 mos</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/54, 1954, to 7/1, 1956, that I last saw the deceased alive on 7/1, 1956, and that death occurred at 8:45 P.m., from the causes and on the date stated above.

SIGNATURE Daniel P. Dineen ADDRESS Glenn Dale Hospital, Glenn Dale, Md. DATE SIGNED 7/1/56

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5 July 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
DATE REC'D BY LOCAL REG. <u>7/1/56</u>	REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	24. FUNERAL DIRECTOR <u>Mattingly Funeral Home</u>	ADDRESS <u>131-11th St., S.E., Wash., D.C.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07514

7517

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>			c. LENGTH OF STAY IN 1b <u>5 MIN.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>			d. STREET ADDRESS <u>3204 Bunker Hill Rd</u>		
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>J.</u> Last <u>Martin</u>			4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/79</u>		9. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Westport, N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Michael Flynn</u>		
14. MOTHER'S MAIDEN NAME <u>Hannah Close</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Dorothy M. Basso - Daughter</u> Address <u>address above</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arterio sclerosis</u> DUE TO (c) <u>Generalized arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>5 months</u> <u>18 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. ft. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February, 1956, to JULY 10, 1956, that I last saw the deceased alive on JULY 10, 1956, and that death occurred at 9:10 A., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) 4300 KAYWOOD DR. ; Mt Rainier, Md 20878 DATE SIGNED 7/10/56

ACTUAL SIGNATURE Leon R. Levitsky M.D. 4300 Kaywood Dr. ; Mt Rainier, Md 20878

PHYSICIAN'S NAME (Type) LEON R. LEVITSKY

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u> ADDRESS <u>3200 R.I. Ave. Mt. Rainier</u>		24a. REC'D BY REGISTRAR <u>6/9/56</u> DATE <u>6/9/56</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

CERTIFICATE OF DEATH

100-10000

RECEIVED
JUL 16 1956
BUREAU V. E.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08598

7518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>1 1/2</u> hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>816 Somerset Place</u>							
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>McDaniel</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>17 July 1956</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>30</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>George McDaniel</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Irene Emerick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>mother - as above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Ateloidan</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Trematody</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 17, 1956</u> , to <u>July 17, 1956</u> , that I last saw the deceased alive on <u>July 17, 1956</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u>				ADDRESS (Street, city or town, state) <u>5301 Hamlet H. Riverdale, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>				DATE SIGNED <u>7/17/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>July 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince George Gen Hosp Cheverly Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Perkins</u>				ADDRESS <u>Adelphi</u>			
24a. REC'D BY REGISTRAR <u>DATE 8/8/56</u>				24b. REGISTRAR'S SIGNATURE <u>A. H. Hensch</u>			

2077903XVO

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF DECEASED [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF DECEASED [Illegible]		39. SIGNATURE OF DECEASED [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF DECEASED [Illegible]		45. SIGNATURE OF DECEASED [Illegible]	
46. SIGNATURE OF DECEASED [Illegible]		47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF DECEASED [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF DECEASED [Illegible]		51. SIGNATURE OF DECEASED [Illegible]	
52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF DECEASED [Illegible]		57. SIGNATURE OF DECEASED [Illegible]	
58. SIGNATURE OF DECEASED [Illegible]		59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF DECEASED [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF DECEASED [Illegible]		63. SIGNATURE OF DECEASED [Illegible]	
64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF DECEASED [Illegible]		69. SIGNATURE OF DECEASED [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF DECEASED [Illegible]		87. SIGNATURE OF DECEASED [Illegible]	
88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

BUREAU Y. B.

JUG 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 & 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07515

7519

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>10 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges General Hosp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>2412 Arden Place, SE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laurence CARR Miller</u>		4. DATE OF DEATH Month Day Year <u>July 31 1956</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7 1912</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bldg. Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.A. - US Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee Miller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth CARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES.</u>		16. SOCIAL SECURITY NO. <u>WORLD WARR</u>	
17. INFORMANT <u>Mrs. Jessie Miller (above) wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>medial sternal hemorrhage secondary to an abd aorta tear (arterio)</u> (c) <u>to an abd aorta tear (arterio)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30, 1956</u> , to <u>July 31, 1956</u> that I last saw the deceased alive on <u>July 31, 1956</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. McQuinn</u>		ADDRESS (Street, city or town, state) <u>Prince Georges Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Thomas F. McQuinn</u>		DATE SIGNED <u>7/31/56</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 2, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEPARD HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLEY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Tallorull</u>		ADDRESS <u>3619-14th St NW</u>	
24a. REC'D BY REGISTRAR <u>WASH DC</u>		DATE <u>8-1-56</u>	
24b. REGISTRAR'S SIGNATURE <u>P.A. Hauck</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		Male		White		April 14, 1928		Tomball, Texas		Tomball		United States of America	
MARRIAGE		MARRIED		SINGLE		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
None		None		None		None		None		None		None		None	
EDUCATION		SCHOOLING		COLLEGE		UNIVERSITY		GRADUATE		DATE OF GRADUATION		PLACE OF GRADUATION		CITY OF GRADUATION	
High School		12		None		None		None		None		None		None	
OCCUPATION		BUSINESS		MANUFACTURING		TRANSPORTATION		COMMUNICATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION	
None		None		None		None		None		None		None		None	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
None		None		None		None		None		None		None		None	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		DATE OF MANNER		PLACE OF MANNER		CITY OF MANNER	
None		None		None		None		None		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
None		None		None		None		None		None		None		None	

BUREAU V. S.

AUG 1 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7570

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17517

Reg. Dist. No. 740

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Croome Station		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 301		d. STREET ADDRESS 2199 8th Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Veronica Mitchell		4. DATE OF DEATH Month Day Year July 7 1956	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/53
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Mc Gray		14. MOTHER'S MAIDEN NAME Ada Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		Address Same add as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Compound fracture of the skull (c) DUE TO (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that was in a collision with another car	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3:10 p. m. 7/7/ 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301		20f. (City or town) (County) (State) Croome Station P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 7, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 7/8/56	
22c. NAME OF CEMETERY OR CREMATORY Unity Funeral Home		22d. LOCATION (City, town, or county) (State) New York New York	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhiner & Co. 901-3rd St. S.W. Washington D.C.		24a. REC'D BY REGISTRAR DATE 10 1956	
24b. REGISTRAR'S SIGNATURE John F. Danner			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07518
490

7571

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome Station</u> c. LENGTH OF STAY IN 1b <u>Transient</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route # 301</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u> d. STREET ADDRESS <u>131 Hillside Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Buster Rufus</u> Middle _____ Last <u>Mitchem</u>			4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/7/1924</u>	9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mech.</u>		11. BIRTHPLACE (State or foreign country) <u>So., Car.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Wright</u>				14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Gladys Mitchem Same add as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of the base of the skull, Crushed chest</u> (c) <u>Compound fracture of the left femur</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>In an auto that was in a collision with another car</u>					
20c. TIME OF INJURY Month, Day, Year <u>3:10 a.m. 7/7/56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 301</u>	20f. (City or town) <u>Croome Station</u>	(County) <u>P. G.</u>	(State) <u>Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type)			DATE SIGNED <u>July 7, 1956</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>7/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Martins Funeral Home</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhiner Co. 901-3rd St. S.E.</u> <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John T. Rhiner</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Registrar		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Place		15. Signature of Cemetery		16. Signature of Funeral Home	
17. Signature of Family		18. Signature of Friends		19. Signature of Neighbors		20. Signature of Community	
21. Signature of Church		22. Signature of School		23. Signature of Business		24. Signature of Other	
25. Signature of State		26. Signature of Federal		27. Signature of International		28. Signature of Other	
29. Signature of Other		30. Signature of Other		31. Signature of Other		32. Signature of Other	
33. Signature of Other		34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other		40. Signature of Other	
41. Signature of Other		42. Signature of Other		43. Signature of Other		44. Signature of Other	
45. Signature of Other		46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other		52. Signature of Other	
53. Signature of Other		54. Signature of Other		55. Signature of Other		56. Signature of Other	
57. Signature of Other		58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other		64. Signature of Other	
65. Signature of Other		66. Signature of Other		67. Signature of Other		68. Signature of Other	
69. Signature of Other		70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other		76. Signature of Other	
77. Signature of Other		78. Signature of Other		79. Signature of Other		80. Signature of Other	
81. Signature of Other		82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other		88. Signature of Other	
89. Signature of Other		90. Signature of Other		91. Signature of Other		92. Signature of Other	
93. Signature of Other		94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other		100. Signature of Other	

BUREAU V. 2

JUL 10 1956

RECEIVED

07519

MARYLAND

STATE DEPARTMENT OF HEALTH

7520

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH - COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>	
TOWN <u>Capitol Heights</u>		TOWN <u>Capitol Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>4805 Central Ave</u>	
3. NAME OF DECEASED (First) <u>Augusta</u> (Middle) <u>M</u> (Last) <u>Mareland</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>18</u> (Year) <u>1956</u>	
SEX <u>Female</u>		5. AGE last birthday <u>86</u> yrs. If under 1 year: Months <u>4</u> Days <u>12</u> Hours <u>15</u> Min.	
6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>3-6-1870</u>		9. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <u>Joseph J. Jander</u>		12. MOTHER'S MAIDEN NAME <u>Mary V. Brown</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		14. SOCIAL SECURITY NO. <u>403-49</u>	
15. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		16. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval between Onset and Death	
422.2 Immediate cause (a) <u>chronic myocarditis</u>		5 years	
Antecedent cause(s) (b) <u>chronic cystitis</u>		2 years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
17a. DATE OF OPERATION		17b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1956</u> , to <u>July 18, 1956</u> , that I last saw the deceased alive on <u>7/18/56</u> , 19 <u>56</u> , and that death occurred at <u>12 noon</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Augusta Ruthroche</u> (Degree or title)		ADDRESS <u>1819-6 St. NW</u>	
DATE SIGNED <u>7-18-56</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
DATE <u>7-21-1956</u>		LOCATION (City, town, or county) <u>Suitland, Md</u>	
DATE REC'D BY LOCAL REG. <u>7-18-1956</u>		REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	
FUNERAL DIRECTOR <u>John A. Mattingly</u>		ADDRESS <u>131-11th St SE Wash 300</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7521

CERTIFICATE OF DEATH

07520

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.				d. STREET ADDRESS 300 Addison Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charlotta Middle M. Last Mussante				4. DATE OF DEATH Month July Day 5 Year 19 56			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-17		9. AGE (In years lost birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME STEFANO MUSSANTE				14. MOTHER'S MAIDEN NAME CELESTINA BACCIGALUPPI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARY V. JOSEPH 300 ADDISON RD SEAT PLEASANT MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (c) 6 days							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 56 , to 7/5 , 19 56 , that I last saw the deceased alive on 7/5 , 19 56 , and that death occurred at 12:30 P.M. on the causes and on the date stated above.							
ACTUAL SIGNATURE Max M. Herzberg				ADDRESS (Street, city or town, state) 7016-GREIG ST. SEAT-PLEASANT M.D.			
PHYSICIAN'S NAME (Type) MAX M. HERZBERG				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-9-56		22c. NAME OF CEMETERY OR CREMATORY ST MARY'S		22d. LOCATION (City, town, or county) (State) WASH. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				24. REC'D BY REGISTRAR 1956			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 8

JUL 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7522

CERTIFICATE OF DEATH

07521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MD b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hosp				d. STREET ADDRESS 5702 Landover Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Julian Middle C Last Painter				4. DATE OF DEATH Month July Day 6 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Mar 17, 1909	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Painter				14. MOTHER'S MAIDEN NAME Gernie E. Lowery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Neva Cabbage Address 6001 Jamestown Rd. Hyattsville,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brancho pneumonia 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Alcoholism DUE TO (c) Delirium Tremens							INTERVAL BETWEEN ONSET AND DEATH 2 days 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/3 , 19 56 , to 7/6 , 19 56 , that I last saw the deceased alive on 7/5 , 19 56 , and that death occurred at 6:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon R. Gallin M.D.				ADDRESS (Street, city or town, state) 7206 Coleridge Rd DATE SIGNED 7/6/56			
PHYSICIAN'S NAME (Type) University Hills, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-8-56		22c. NAME OF CEMETERY OR CREMATORY Calverton		22d. LOCATION (City, town, or county) (State) Stonley 2a.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Guscha Sone ADDRESS Hyattsville Md				24a. REC'D BY REGISTRAR R.W. Bedner 24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		OCCUPATION	
EDUCATION		RELIGION	
BIRTH		DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
COUNTY		STATE	

BUREAU V. 2

JUL 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

17522
243

7485

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Pennsylvania</u> b. COUNTY <u>Susquehanna</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN lb <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3330 Lancer Drive</u>			d. STREET ADDRESS <u>201 South Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Eleanor Parke</u>			4. DATE OF DEATH <u>July 19 19 56</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 13, 1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garment worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garments</u>		11. BIRTHPLACE (State or foreign country) <u>Wales</u>	
13. FATHER'S NAME <u>John Henry Lewis</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Ann Leyshon</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Malvis Duffy, Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lacerated wound of neck and throat</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted wound with razor blade.</u>			
20c. TIME OF INJURY Month, Day, Year <u>11.00 AM 7-19-56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>House</u>		20f. (City or town) (County) (State) <u>Hyattsville- Pr. Gee. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>July 19, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rondo Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Hersh...</u>		ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>James...</u>	
				24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALT. MD. 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 24 1956

RECEIVED

07523

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

7572 CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D. C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Glenn Dale (rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Washington 47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Hospital</u>		STREET ADDRESS (If rural, give location) <u>3921 Georgia Ave., N. W.</u>	
3. NAME OF DECEASED (Type or Print) <u>EDWIN L. PARKER</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>15</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/26/1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News Vendor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
13. FATHER'S NAME <u>Andrew L. Parker</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Bowman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Cor Pulmonale</u>			<u>13 wks.</u>
Antecedent cause(s) (b) <u>Pulmonary Tuberculosis</u>			<u>5 yrs 8 mos.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1:30, 1956, to 7:15, 1956, that I last saw the deceased alive on 7:15, 1956, and that death occurred at 3:10 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Hospital

DATE SIGNED

7/15/56

23. BURIAL OR CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<u>7-18-56</u>	<u>Fair Lincoln Cemetery</u>	<u>Bladensburg Rd. P. O. Box 1044</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>7/16/56</u>	<u>W. W. Weiss</u>	<u>W. W. Weiss</u>	<u>W. W. Weiss</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. A.

JUL 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7491

CERTIFICATE OF DEATH

07524

Reg. Dist. No. 2N5

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>8 years</u>				d. STREET ADDRESS <u>7210 15th Ave. Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7210 15th Ave Tak. PK Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>CHARLES</u> Middle <u>POWERS</u> Last				4. DATE OF DEATH <u>JULY</u> Month <u>18</u> Day <u>1956</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Powers</u>				14. MOTHER'S MAIDEN NAME <u>Julia Donahue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Francis E. Powers, 9702 23rd Ave Adelphi, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Cancer of Kidney & Metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>11</u> <u>8 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>56</u> , to <u>July 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>56</u> , and that death occurred at <u>7:50 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9703 Rags Rd Adelphi, Md.</u> DATE SIGNED <u>7/18/56</u>							
ACTUAL SIGNATURE <u>Claire A. Christman</u> M.D.				PHYSICIAN'S NAME (Type) <u>CLAIRE A. CHRISTMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Transit Burial</u>		<u>July 21, 1956</u>		<u>St. Joseph's Cemetery</u>		<u>Batavia, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Powers</u> ADDRESS <u>254 Carroll St. N.W. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>July 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> Deputy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

JUL 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7523

CERTIFICATE OF DEATH

07525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Hts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.				d. STREET ADDRESS 402-59th. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Rackey Last Rackey				4. DATE OF DEATH Month July Day 5 Year 56			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-80		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE A. CHISM				14. MOTHER'S MAIDEN NAME MARY BLAKNEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MAURICE F. RACKY Address 5901 ALLENTOWN WASH 22, D.C.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Congestive Heart-Failure = Pulmonary Edema DUE TO Hypertensive Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. f. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 19 53 to JULY 5, 19 56 , that I last saw the deceased alive on JULY 5, 19 56 , and that death occurred at 12:25 P.M. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Max W. Herzberg				ADDRESS (Street, city or town, state) DATE SIGNED 7016 - GRIG ST. SEAT-PLA-DANT, M.D.			
PHYSICIAN'S NAME (Type) MAX M. HERZBERG.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-9-56		22c. NAME OF CEMETERY OR CREMATORY ST BARNABAS		22d. LOCATION (City, town, or county) (State) Oxon Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 5717-11st St		24a. REC'D BY REGISTRAR W. W. Chambers	
				24b. REGISTRAR'S SIGNATURE W. W. Chambers			

ANNOUNCING STATE DEPARTMENT OF HEALTH-BALTIMORE 19
 CERTIFICATE OF DEATH

NAME OF DECEASED FRANCIS J. BROWN		DATE OF DEATH JULY 1956	
AGE 45		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED	
PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. BROWN		SIGNATURE OF REGISTRAR J. H. BROWN	
DATE JULY 1956		TIME 10:00 AM	

RECEIVED
 JUL 9 1956
 BUREAU V. 2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

240

7573

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Croome Station		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 301				d. STREET ADDRESS 2199 8th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucille Middle Last Ravnall				4. DATE OF DEATH Month July Day 7 Year 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/1/32		9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lodrus Ravnall				14. MOTHER'S MAIDEN NAME Lucille Ravnall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Alex Ravnall 62 West 127th St. N.Y., N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured base of the skull, crushed chest DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collision with another car					
20c. TIME OF INJURY Month, Day, Year 3:10 p.m. 7/ 7 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301		20f. (City or town) (County) (State) Croome Station P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				DATE SIGNED July 7, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 7/8/56		22c. NAME OF CEMETERY OR CREMATORY Unity Funeral Home		22d. LOCATION (City, town, or county) (State) New York City N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE John I. Hunter + Co. 901-3rd St S.W. Washington D.C.				24a. REC'D BY REGISTRAR DATE 10 1956		24b. REGISTRAR'S SIGNATURE John L. Deane	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan and the orientation of the document.

BUREAU V. S.

JUL 10 1956

RECEIVED

7574

CERTIFICATE OF DEATH

67522

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDMONSTON</u>				c. LENGTH OF STAY IN TB <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5024-46th AVENUE</u>				d. STREET ADDRESS <u>5024-46th AVENUE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALBERT Wellington Redd</u>				4. DATE OF DEATH Month Day Year <u>July 24 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-25-1891</u>	
9. AGE (In years, last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. <u>8 10 — —</u>		IF UNDER 24 HRS. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>William Redd</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR II - 1942-46</u>				16. SOCIAL SECURITY NO. <u>ETHEL R. REDD - Edmonston Md.</u>			
17. INFORMANT Address <u>ETHEL R. REDD - Edmonston Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA (Hypostatic)</u> <u>199.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA, STOMACH & INTESTINE</u> DUE TO (c) <u>OPERATION FOR (b) CARCINOMA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>1954</u> <u>9-1955</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HETEROPLASIA - MARCH, 1952</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-15-1956</u> to <u>7-24-1956</u> , that I last saw the deceased alive on <u>7-24-1956</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Spiller</u>				ADDRESS (Street, city or town, state) <u>4506 RIA AVE BRENTWOOD, Md.</u>			
DATE SIGNED <u>7-24-56</u>							
PHYSICIAN'S NAME (Type) <u>William W. Spiller</u>				M.D. <u>MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington Mt.</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ernest ARON - 1432 York St. Wash. D.C.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>July 27 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mr. Jas. Severe</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7524

CERTIFICATE OF DEATH

Reg. Dist. No. 07528

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chertsey		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colman Manor		x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hosp. Hager				d. STREET ADDRESS 3907 Lawrence		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas First Middle Last Reid				4. DATE OF DEATH July 9 19 56			
5. SEX m		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years (last birthday) 76		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Glasco, Scotland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert W. Reid				14. MOTHER'S MAIDEN NAME Mary Norton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-10-4339		17. INFORMANT Mr. Robert W. Reid Address 5615-35th Ave. Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
4201 DUE TO Myocardial infarction with mural thrombosis						2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Thrombosis of Left Coronary Artery						2 weeks	
(c) Coronary arteriosclerotic heart disease						years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy with uremia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/2/1956 to 5/7/1956, that I last saw the deceased alive on July 9 1956, and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur J. Wilets				DATE SIGNED July 10, 1956			
PHYSICIAN'S NAME (Type) ARTHUR J. WILETS				ADDRESS (Street, city or town, state) 3717 38th Ave. Cottage City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/12/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery, Colman Manor, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS - Riverdale Md.		24a. RECEIVED BY REGISTRAR DATE 1-3-1956	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		MARRIAGE		PLACE OF BIRTH	
JAMES J. JONES		MARRIED		NEW YORK	
AGE		SEX		RACE	
35		M		W	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JUL 13 1956		NEW YORK		HEART DISEASE	
TIME OF DEATH		HOURS		MINUTES	
10:00		10		00	
DATE OF BURIAL		PLACE OF BURIAL		CAUSE OF BURIAL	
JUL 15 1956		NEW YORK		HEART DISEASE	
TIME OF BURIAL		HOURS		MINUTES	
12:00		12		00	
DATE OF INTERMENT		PLACE OF INTERMENT		CAUSE OF INTERMENT	
JUL 15 1956		NEW YORK		HEART DISEASE	
TIME OF INTERMENT		HOURS		MINUTES	
12:00		12		00	
DATE OF CREMATION		PLACE OF CREMATION		CAUSE OF CREMATION	
JUL 15 1956		NEW YORK		HEART DISEASE	
TIME OF CREMATION		HOURS		MINUTES	
12:00		12		00	
DATE OF EXHUMATION		PLACE OF EXHUMATION		CAUSE OF EXHUMATION	
JUL 15 1956		NEW YORK		HEART DISEASE	
TIME OF EXHUMATION		HOURS		MINUTES	
12:00		12		00	

RECEIVED
JUL 13 1956
BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
Reg. Dist. No. 07529 731																			
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Delaware b. COUNTY New Castle														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.					d. STREET ADDRESS 729 Clayton Street														
3. NAME OF DECEASED (Type or print) First Frances Middle Mary Last Reynolds					4. DATE OF DEATH Month July Day 23 Year 19 56														
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-31-31		9. AGE (In years last birthday) 24 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
13. FATHER'S NAME Lawrence Reynolds					14. MOTHER'S MAIDEN NAME Frances Shearer														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 222-16-8704					17. INFORMANT Margaret Reynolds Address Same address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self inflicted poisoning by Barbiturates DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 970.2 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour 10.00 p. m. 7-22- 19 56					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home									
20f. (City or town) Cheverly, Pr. Geo. Md.					20g. (County) Pr. Geo.					20h. (State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE John T. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 7-23-56									
EXAMINER'S NAME (Type) John T. Maloney, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal					22b. DATE THEREOF 7/23/56					22c. NAME OF CEMETERY OR CREMATORY Wilmington									
22d. LOCATION (City, town, or county) Delaware					22e. (State) Delaware					22f. (Country) U.S.A.									
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					ADDRESS Hyattsville, Maryland.					24a. REC'D BY REGISTRAR 27 1956									
24b. REGISTRAR'S SIGNATURE A. H. Hedrick					24c. (Date) 7-23-56					24d. (Signature) A. H. Hedrick									

MISSOURI STATE DEPARTMENT OF HEALTH - BULLETIN 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 2

JUL 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07500

7526

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
c. LENGTH OF STAY IN 1b <u>17 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u>		d. STREET ADDRESS <u>6915 B. St. Seat Pleasant</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eldred</u> Middle <u>Harvey</u> Last <u>Rhine</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1898</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laurel, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard H. Rhine</u>		14. MOTHER'S MAIDEN NAME <u>Alice F. Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Martha V. Rhine, Seat Pleasant, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 1952, to <u>10 July</u> , 1956, that I last saw the deceased alive on <u>10 July</u> , 1956, and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas M. Hutchins</u>		ADDRESS (Street, city or town, state) <u>7315 Landover Rd. Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas M. Hutchins</u>		DATE SIGNED <u>July 11, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 13, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Landover Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Basch, son</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>J. J. Jones</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Jones</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]		7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]	
9. DATE OF DEATH [Illegible]		10. TIME OF DEATH [Illegible]		11. PLACE OF DEATH [Illegible]		12. CAUSE OF DEATH [Illegible]	
13. MEDICAL HISTORY [Illegible]		14. PRESENT ILLNESS [Illegible]		15. TREATMENT [Illegible]		16. SIGNATURE OF PHYSICIAN [Illegible]	
17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF WITNESSES [Illegible]		19. SIGNATURE OF REGISTRAR [Illegible]		20. SIGNATURE OF CLERK [Illegible]	

BUREAU V. 3

JUL 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7575

CERTIFICATE OF DEATH

Reg. Dist. No. 07531

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. #1</u>				d. STREET ADDRESS <u>R.F.D. #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>HOOVER</u> Last <u>ROBINETTE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 12 1881</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>WASHINGTON D.C.</u>	
13. FATHER'S NAME <u>DICKERSON N. HOOVER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE M. SCHEITLIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FRED G. ROBINETTE JR.</u>		Address <u>R.F.D. #1 LANHAM MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis Agitans</u> <u>350 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Nov.</u> 19 <u>55</u> , to <u>July 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Quora J. Lee</u> M.D.				ADDRESS (Street, city or town, state) <u>4314 Gallatin St. Hyattsville</u>			
PHYSICIAN'S NAME (Type) <u>Hyattsville</u>				DATE-SIGNED <u>7/6/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>7-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees Sons - 300-45th WASH D.C.</u>				ADDRESS <u>300-45th WASH D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

DECEASED'S SEX AND AGE AT DEATH

DECEASED'S OCCUPATION

DATE

TIME

PLACE

CAUSE

DIAGNOSIS

DATE

TIME

PLACE

CAUSE

DIAGNOSIS

DATE

TIME

PLACE

BUREAU V. 2

JUL 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7527

CERTIFICATE OF DEATH

Reg. Dist. No. 07532

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley, Md.				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges Gen. Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert HENRY Robinson				4. DATE OF DEATH July 5, 19 56			
5. SEX m		6. COLOR OR RACE w		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29-1914 42 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Oxon Hill				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Albert H. Robinson				14. MOTHER'S MAIDEN NAME Cornelia Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia DUE TO 260X (b) ACUTE RENAL PAPILLITIS DUE TO (c) DIABETES MELLITUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2233							INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 6 DAYS 5 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholism Epilepsy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/30, 19 56 to 7/5, 19 56 that I last saw the deceased alive on 7/4, 19 56, and that death occurred at 440 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Donald Greene				ADDRESS (Street, city or town, state) M.D. 3503 Perry St. Mt Prince Md 7/5/56			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 7-56		22c. NAME OF CEMETERY OR CREMATORY St Barnabas		22d. LOCATION (City, town, or county) Oxon Hill Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
ADDRESS 1661- Good Hope Rd Washington D.C.				DATE			

JUL 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07533
231

7528

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo. Gen. Hosp.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First EVA Middle RUTH Last ROTH			4. DATE OF DEATH Month July Day 25 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Oct 1900		9. AGE (In years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George Kunkle		
14. MOTHER'S MAIDEN NAME Chrissie Dietz			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT AUSTIN L. BOTH (Husband) Same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO (b) Chronic Schistocytosis (c) Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) York, Pa.			20g. (County) (State)		
21. I certify that I attended the deceased from 8-25 , 19 56 , to 7-25 , 19 56 , that I last saw the deceased alive on 7-25 , 19 56 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Albert Roth			DATE SIGNED ALBERT ROTH, M.D. 5510 MADISON ST. RIVERDALE, MD.		
PHYSICIAN'S NAME (Type) Albert Roth			ADDRESS (Street, city or town, state) 5510 Madison St. Riverdale, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Rose Cemetery	
22d. LOCATION (City, town, or county) York, Pa.		22e. (State) Pa.		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Maryland		
24a. REC'D BY REGISTRAR JUL 27 1956			24b. REGISTRAR'S SIGNATURE J. H. Sedwick		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		M		35		JAN 15 1900		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		SUICIDE		JUL 27 1956		BALTIMORE		MD		USA			
EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		TEMPERATURE		PULSE	
HIGH SCHOOL		CATHOLIC		WHITE		WHITE		5' 10"		175		98.6		72	
MARRIAGE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY			
MAY 15 1925		BALTIMORE		MD		USA									
PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS SUICIDES		PREVIOUS MURDERS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
JUL 27 1956		BALTIMORE		MD		USA									
MARRIAGE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY			
MAY 15 1925		BALTIMORE		MD		USA									
PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS SUICIDES		PREVIOUS MURDERS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	

RECEIVED
JUL 27 1956
BUREAU V. R.

7529

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General		d. STREET ADDRESS 4304-29th Street	
3. NAME OF DECEASED (Type or print) First Middle Last Julia A. Sampson		4. DATE OF DEATH Month Day Year July 23 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY in own home	9. AGE (In years last birthday) 78 yrs.
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Wm. Wilding		14. MOTHER'S MAIDEN NAME Jane V. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jane V. Pickeral		Address 4304-29th St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X (b) Hypertensive Cardio-Vascular - Renal DUE TO (c) Disease INTERVAL BETWEEN ONSET AND DEATH 4 days 9 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/26, 1947, to 7/23, 1956 that I last saw the deceased alive on July 23, 1956, and that death occurred at 345 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. C. Hageage		DATE SIGNED Mt. Rainier, Md.	
PHYSICIAN'S NAME (Type) C. C. Hageage M.D.		Mt. Rainier, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/26/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		24a. READ BY REGISTRAR 24b. REGISTRAR'S SIGNATURE D. W. Hedrick	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 27 1956

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. SIGNATURE OF PHYSICIAN</p>		<p>10. SIGNATURE OF REGISTRAR</p>	
<p>11. DATE OF DEATH</p>		<p>12. TIME OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. SIGNATURE OF WITNESSES</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF BURIAL OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CHURCH OFFICIAL</p>		<p>20. SIGNATURE OF CEMETERY OFFICIAL</p>	
<p>21. SIGNATURE OF MINISTRY OFFICIAL</p>		<p>22. SIGNATURE OF OTHER OFFICIAL</p>	
<p>23. SIGNATURE OF OTHER OFFICIAL</p>		<p>24. SIGNATURE OF OTHER OFFICIAL</p>	
<p>25. SIGNATURE OF OTHER OFFICIAL</p>		<p>26. SIGNATURE OF OTHER OFFICIAL</p>	
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<p>53. SIGNATURE OF OTHER OFFICIAL</p>		<p>54. SIGNATURE OF OTHER OFFICIAL</p>	
<p>55. SIGNATURE OF OTHER OFFICIAL</p>		<p>56. SIGNATURE OF OTHER OFFICIAL</p>	
<p>57. SIGNATURE OF OTHER OFFICIAL</p>		<p>58. SIGNATURE OF OTHER OFFICIAL</p>	
<p>59. SIGNATURE OF OTHER OFFICIAL</p>		<p>60. SIGNATURE OF OTHER OFFICIAL</p>	
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<p>63. SIGNATURE OF OTHER OFFICIAL</p>		<p>64. SIGNATURE OF OTHER OFFICIAL</p>	
<p>65. SIGNATURE OF OTHER OFFICIAL</p>		<p>66. SIGNATURE OF OTHER OFFICIAL</p>	
<p>67. SIGNATURE OF OTHER OFFICIAL</p>		<p>68. SIGNATURE OF OTHER OFFICIAL</p>	
<p>69. SIGNATURE OF OTHER OFFICIAL</p>		<p>70. SIGNATURE OF OTHER OFFICIAL</p>	
<p>71. SIGNATURE OF OTHER OFFICIAL</p>		<p>72. SIGNATURE OF OTHER OFFICIAL</p>	
<p>73. SIGNATURE OF OTHER OFFICIAL</p>		<p>74. SIGNATURE OF OTHER OFFICIAL</p>	
<p>75. SIGNATURE OF OTHER OFFICIAL</p>		<p>76. SIGNATURE OF OTHER OFFICIAL</p>	
<p>77. SIGNATURE OF OTHER OFFICIAL</p>		<p>78. SIGNATURE OF OTHER OFFICIAL</p>	
<p>79. SIGNATURE OF OTHER OFFICIAL</p>		<p>80. SIGNATURE OF OTHER OFFICIAL</p>	
<p>81. SIGNATURE OF OTHER OFFICIAL</p>		<p>82. SIGNATURE OF OTHER OFFICIAL</p>	
<p>83. SIGNATURE OF OTHER OFFICIAL</p>		<p>84. SIGNATURE OF OTHER OFFICIAL</p>	
<p>85. SIGNATURE OF OTHER OFFICIAL</p>		<p>86. SIGNATURE OF OTHER OFFICIAL</p>	
<p>87. SIGNATURE OF OTHER OFFICIAL</p>		<p>88. SIGNATURE OF OTHER OFFICIAL</p>	
<p>89. SIGNATURE OF OTHER OFFICIAL</p>		<p>90. SIGNATURE OF OTHER OFFICIAL</p>	
<p>91. SIGNATURE OF OTHER OFFICIAL</p>		<p>92. SIGNATURE OF OTHER OFFICIAL</p>	
<p>93. SIGNATURE OF OTHER OFFICIAL</p>		<p>94. SIGNATURE OF OTHER OFFICIAL</p>	
<p>95. SIGNATURE OF OTHER OFFICIAL</p>		<p>96. SIGNATURE OF OTHER OFFICIAL</p>	
<p>97. SIGNATURE OF OTHER OFFICIAL</p>		<p>98. SIGNATURE OF OTHER OFFICIAL</p>	
<p>99. SIGNATURE OF OTHER OFFICIAL</p>		<p>100. SIGNATURE OF OTHER OFFICIAL</p>	

JUL 27 1956

RECEIVED

BUREAU V. B.

7530 CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> TOWN <u>LAUREL</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LAUREL SANITARIUM</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>P. GEORGES</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>MOUNT RAINIER</u> TOWN <u>16</u> STREET ADDRESS <u>3802 30th STREET</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>FLORENCE</u> (Middle) <u>M.</u> (Last) <u>SCHENKINGER</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>10</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Oct. 4/74</u>
9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>WASHINGTON SHAW SCHENKINGER</u>		14. MOTHER'S MAIDEN NAME <u>MAUD HAYES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> (If Yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMATION & ADDRESS <u>HOSPITAL RECORDS</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 334X IMMEDIATE CAUSE (A) <u>Hypostatic pneumonia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Psychosis with cerebral Arterio-</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u> </u>		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) <u> </u>	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>	
22. I hereby certify that I attended the deceased from <u>6-9</u> , 19 <u>56</u> , to <u>7-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-10</u> , 19 <u>56</u> , and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>Edna P. Matamor</u> M.D.		ADDRESS (Street, city, town, state) <u>Laurel Sanitarium Laurel Md</u>	
DATE SIGNED <u>July 10 1956</u>		DATE SIGNED <u>July 10 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/12/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. REC'D BY REGISTRAR <u>JUL 16 1956</u>		REGISTRAR'S SIGNATURE <u>William M. Buchanan</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier, Md.</u>	

INSTRUCTIONS

1 The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

3 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7576
CERTIFICATE OF DEATH

07536

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale Md</u>				c. LENGTH OF STAY IN 1b <u>37 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 58</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale, Md.</u>			
				d. STREET ADDRESS <u>Box 58</u>			
3. NAME OF DECEASED (Type or print) <u>Clarence</u> <u>Bradley</u> <u>Seaton</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1878</u>	
				9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Agriculture Dept U S Gov't</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U S Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Sam Seaton</u>				14. MOTHER'S MAIDEN NAME <u>Annie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Gerald Seaton</u> <u>Glenn Dale Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary artery occlusion with infarction</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>generalized arteriosclerosis</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u> <u>year</u> <u>year</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u></p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 1950</u> to <u>July 16, 1956</u> , that I last saw the deceased alive on <u>July 15, 1956</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. James Kurtz</u> M.D.				ADDRESS (Street, city or town, state) <u>RFD Bowie Md.</u> DATE SIGNED <u>7/16/56</u>			
PHYSICIAN'S NAME (Type) <u>H. James Kurtz</u>				<u>RFD Bowie Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 18, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24. REC'D BY REGISTRAR <u>July 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. McH...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Charles</i>		SEX <i>Male</i>		AGE <i>25</i>	
DATE OF DEATH <i>July 19, 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Student</i>	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 3

JUL 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07539
243
Reg. Dist. No.

7577

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS (If rural, give location) 404 Richardson St., N. W.	
3. NAME OF DECEASED (First) (Middle) (Last) SOPHIE SMITH		4. DATE OF DEATH (Month) (Day) (Year) 7 14 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated	8. DATE OF BIRTH 10/17/1918
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		9b. KIND OF BUSINESS OR INDUSTRY Elite Laundry	9. AGE last birthday 37 yrs.
10a. BIRTHPLACE (State or foreign country) Saluda, S. Carolina		10. CITIZEN OF WHAT COUNTRY? USA	
11. FATHER'S NAME Charlie Jones		12. MOTHER'S MAIDEN NAME Sara Simpkins	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		14. SOCIAL SECURITY NO. 577-30-5205	
15. INFORMANT AND ADDRESS Decedent			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Cor Pulmonale				1 mo	
Antecedent cause(s) (b) Pulmonary Tuberculosis				10 1/2 yrs	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6-14, 1950, to 7-14, 1956, that I last saw the deceased alive on 7-14, 1956, and that death occurred at 6:20 a.m., from the causes and on the date stated above.					
SIGNATURE Daniel Leo Pinesane M.D.		ADDRESS Glenn Dale Hospital Glenn Dale, Md.		DATE SIGNED 7/14/56	
23. BURIAL, CREMATION REMOVAL (Specify) 7/15/56		DATE 7/15/56		NAME OF CEMETERY OR CREMATORY Washington D.C.	
DATE REC'D BY LOCAL REG. 7/14/56		REGISTRAR'S SIGNATURE Hue Weiss		24. FUNERAL DIRECTOR Hazen Funerary 389 RI	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUL 20 1956

BUREAU V. I.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7578

CERTIFICATE OF DEATH

07540

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1803 Madre St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELSIE C. SNYDER				4. DATE OF DEATH Month Day Year July 3 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1890	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---			
11. BIRTHPLACE (State or foreign country) Pa.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Joseph Miller				14. MOTHER'S MAIDEN NAME Mary Voygt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Mrs. Dorothy S. Usalis, 1803 Madre St., Silver Spring, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA LIVER 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE TOXEMIA & ASCITES INTERVAL BETWEEN ONSET AND DEATH 9 MOS.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 3, 1956, to July 3, 1956, that I last saw the deceased alive on July 3, 1956, and that death occurred at 8 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Quinn - MD.				DATE SIGNED July 3/1956			
ADDRESS (Street, city or town, state) 501-B Southampton Lane, Silver Spring - Md.							
PHYSICIAN'S NAME (Type) THOMAS F. QUINN - MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/56		22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.		22d. LOCATION (City, town, or county) (State) Metees Rocks Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home				ADDRESS 5103 Wis., Ave., N.W.		24a. REC'D BY REGISTRAR DATE July 9, 1956	
24b. REGISTRAR'S SIGNATURE Mrs. Jas. Senechal				Signature			

ST. JOHN'S HOSPITAL TO INVESTIGATE STATE CHAIRMAN

JUL 12 1956

RECEIVED

7531

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6402 Grieg Street			
3. NAME OF DECEASED (Type or print) First Charles Middle O Last Stone				4. DATE OF DEATH Month July Day 2 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1886		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter-Retired		10b. KIND OF BUSINESS OR INDUSTRY painter		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Stone				14. MOTHER'S MAIDEN NAME Emily Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. J W W 1		17. INFORMANT Address Dr. Kurland Mt. Alto Hosp. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Lebar Pneumonia (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED July 3, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-6-1956	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL. ARLINGTON VA.		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		ADDRESS 517-11st St		24a. REC'D BY REGISTRAR 6		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18

Item 7 FilmG200 7-24-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

67543

7532

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>34 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>3563-55th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julius</u> First Middle Last <u>Stone</u>				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-2-1891</u>	
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - U.S. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph D. Stone</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Statistic Card</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.1</u> DUE TO <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>34 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRALEMBOLUS, PULMONARY INFARCT</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-14-</u> 19 <u>56</u> to <u>7-18</u> 19 <u>56</u> , that I last saw the deceased alive on <u>7-18</u> 19 <u>56</u> , and that death occurred at <u>12:02</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, State) <u>5570 Madison St, W. Hyattsville Md.</u> DATE SIGNED <u>7-18-56</u>							
ACTUAL SIGNATURE <u>Albert Roth</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>W. Hyattsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons, 3501 14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>July 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH JUL 20 1956	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CERTIFICATE NO. [Faint text]		COUNTY [Faint text]	

BUREAU V. 2

JUL 20 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use. For removal to the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07544
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

239

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	c. LENGTH OF STAY IN 1b 2 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308 Main Street		d. STREET ADDRESS 308 Main Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Fred Twiggs Stuart		4. DATE OF DEATH July 28, 19 56	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-26-87
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman		10b. KIND OF BUSINESS OR INDUSTRY Lumber	11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Stuart	
14. MOTHER'S MAIDEN NAME Salhe Irwin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Walthe Irwin south Carolina	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute congestive heart failure DUE TO (b) Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 29, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/56	22c. NAME OF CEMETERY OR CREMATORY McCormick
22d. LOCATION (City, town, or county) south Carolina		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F Gosch's sons Hyattsville Md		ADDRESS	
24a. REC'D BY REGISTRAR AUG 5 1956		24b. REGISTRAR'S SIGNATURE Nellie Brashers	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

AUG 5 1956

RECEIVED

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17534

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Keloland Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie Drene Suddeth</u>		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-01</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Coligny</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hosp records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>181x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF BLADDER</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS</u> <u>1-2 YRS</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-18</u> , 19 <u>56</u> , to <u>7-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-27</u> , 19 <u>56</u> , and that death occurred at <u>7:55</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. J. Houmann</u>		ADDRESS (Street, city or town, state) <u>4404 QUEENSBURY RD</u> DATE SIGNED <u>7-28-56</u>	
PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>		RIVERDALE MD.	
22a. BURIAL, CREMATION, REMAINS (Specify)	22b. DATE THEREOF <u>7-31-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cork Inc. 1217 St. Paul St.</u>		24a. REC'D BY REGISTRAR <u>DATE 7/30/56</u>	24b. REGISTRAR'S SIGNATURE <u>Jac. Seewer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

JUL 31 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07546

7486

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2128 Saranac St</u>				d. STREET ADDRESS <u>2128 Saranac St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LORAIN F. SULLIVAN</u>				4. DATE OF DEATH Month Day Year <u>July 24 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 31. 1927</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>JAMES CROSTEN</u>				14. MOTHER'S MAIDEN NAME <u>ALICE ROBINSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>PAUL SULLIVAN</u> Address <u>HUSBAND ABUSE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>± 10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1955</u> to <u>July 22, 1956</u> , that I last saw the deceased alive on <u>July 22, 1956</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold J. Lear</u> M.D. <u>4314 Gallatin St.</u> <u>7/24/56</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>A. A. LEAR, M.D.</u> <u>Hyattsville, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 25, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peter & Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. V. Talbot</u> ADDRESS <u>3619-1X 14th Ave NW</u> <u>Wash DC</u>				24a. RECEIVED BY REGISTRAR DATE <u>July 24 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> <u>deputy</u>			

CERTIFICATE OF DEATH

Form with various fields for death certificate, including name, date, and cause of death. The text is mostly illegible due to blurriness.

BUREAU V. S.

JUL 25 1956

RECEIVED

Form with fields for date, time, and location of death. Includes a signature line.

7535

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princedale md.</u>				c. LENGTH OF STAY IN 1b <u>1 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Selma Memorial, Quindary Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>HILL</u> Last <u>TITUS</u>				4. DATE OF DEATH <u>30</u> Month <u>7</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-16-81</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>30</u> Hours <u>30</u> Min. <u>19</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>30</u> Hours <u>30</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmond Hill</u>				14. MOTHER'S MAIDEN NAME <u>ANNA Nuttall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Helen P. Hill</u> Address <u>Laurel, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insuff.</u> DUE TO <u>Ch. Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Myocarditis</u> DUE TO (c) <u>Ch. Myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>6 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia - Terminal</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>th</u>	
20f. (City or town) <u>Laurel</u> (County) <u>md</u> (State) <u>md</u>				20g. (City or town) <u>Laurel</u> (County) <u>md</u> (State) <u>md</u>			
21. I certify that I attended the deceased from <u>May 1st</u> 19 <u>56</u> , to <u>July 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>56</u> , and that death occurred at <u>2 p.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank E. Shipley</u>				ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>7/30/56</u>			
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) <u>Laurel</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. Rolden</u> ADDRESS <u>Laurel Md</u>				24a. REC'D BY REGISTRAR <u>Aug 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> Deputy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. C.

AUG 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7536

CERTIFICATE OF DEATH

Reg. Dist. No.

0754845

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b Hyattsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital			d. STREET ADDRESS 3900 Hamilton Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First William Middle Robert Last Trammel			4. DATE OF DEATH Month July Day 19 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1889	9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee	
13. FATHER'S NAME Charles Trammel.		14. MOTHER'S MAIDEN NAME Estelle Kimbel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Record, Leland Mem. Hosp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum DUE TO (b) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis agitans					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 15, 1956 , to July 19, 1956 , that I last saw the deceased alive on July 19, 1956 , and that death occurred at 9:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4404 Queensbury Rd., Riverdale, Md. DATE SIGNED July 19, 1956					
ACTUAL SIGNATURE C. J. Houmann M.D.					
PHYSICIAN'S NAME (Type) Carl J. Houmann					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/56	22c. NAME OF CEMETERY OR CREMATORY Canton		22d. LOCATION (City, town, or county) (State) North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Francis Garach Sons		ADDRESS 4739 Baltimore Hyattsville, Md.		24a. REC'D BY REGISTRAR 24 1956	24b. REGISTRAR'S SIGNATURE Gas. Leary

CERTIFICATE OF DEATH

NAME OF DECEASED William George		DATE OF DEATH June 19, 1956	
PLACE OF DEATH Baltimore, Maryland		AGE 45	
OCCUPATION Salesman		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DATE OF BIRTH June 19, 1911	
SEX Male		RACE White	
EDUCATION High School		RELIGION Roman Catholic	
MARRIAGE Married		SPOUSE Mary Ann	
BIRTHPLACE Maryland		RESIDENCE Baltimore, Maryland	
PREVIOUS ILLNESS None		PHYSICIAN Dr. J. H. Smith	
HOSPITAL None		BURIAL St. Mary's Cemetery	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith	

BUREAU V. S.

JUL 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07549

Reg. Dist. No. 245

7537

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>4620 Garrett Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Quinton</u> Last <u>Waskey</u>			4. DATE OF DEATH Month <u>July</u> Day <u>3rd</u> Year <u>1956</u>										
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1933</u>		9. AGE (In years last birthday) <u>23</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Animal husbandryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Live stock</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Ernest Waskey</u>										
14. MOTHER'S MAIDEN NAME <u>Mary Ethel Smith</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>										
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Father-4620 Garrett Ave, Beltsville, Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Shotgun wound of abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot during an altercation</u>											
20c. TIME OF INJURY Month, Day, Year <u>1:30 a.m. 7-3-56</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home of accused</u>									
20f. (City or town) <u>Beltsville</u>		(County) <u>Pr. Geo.</u>		(State) <u>Md.</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John T. Maloney</u>		EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <u>July 3, 1956</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 6/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>									
22d. LOCATION (City, town, or county) <u>Pr. Geo. Co.</u>		<u>Riggs Rd. Extd. Hyattsville, Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Md.</u>			24a. REC'D BY REGISTRAR <u>July 5 1956</u>										
24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severel</u>			<u>Deputy</u>										

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records or for burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH-BATHING & RECREATION

RECEIVED
JUL 9 1956
BUREAU V. 8

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Ranier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Ranier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 4701 27th Street	
3. NAME OF DECEASED (Type or print) First MIDDLE Last DAVID WERNER		4. DATE OF DEATH July 8 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1 - 1888
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aaron		14. MOTHER'S MAIDEN NAME Hannah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 116-035691	
17. INFORMANT Philip Wernerton		Address 3511 Leanderfoot St. NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 MYOCARDIAL INFARCTION DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) CORONARY ARTERIO-SCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/16/56, 19, to 7/8/56, 19, that I last saw the deceased alive on 7/5/56, 19, and that death occurred at 9:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William S. Miller M.D.		ADDRESS (Street, city or town, state) 1835 - EYE ST N.W. DATE SIGNED	
PHYSICIAN'S NAME (Type) William S. Miller, M.D.		Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10-1956	22c. NAME OF CEMETERY OR CREMATORY Chesholom	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goldberg Funeral Home Wash. D.C.		24a. REC'D BY REGISTRAR DATE July 13 1956	24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe Deputy

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

DATE OF DEATH

DECEASED

DATE OF BIRTH

DECEASED

DECEASED

DATE OF BIRTH

DECEASED

DECEASED

DECEASED

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DECEASED

BUREAU V. 3

JUL 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7487

CERTIFICATE OF DEATH

Reg. Dist. No.

07551

245

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6519 Colesville Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES AUGUSTUS WILER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 25, 1876</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railway Postal Clerk, retired (U.S. Gov't.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pittsburg, Pa.</u>			
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Wiler</u>				14. MOTHER'S MAIDEN NAME <u>Mary Spargo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss M. Thelma Wiler, 6519 Colesville Rd.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Parkinsonism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>@ 5 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/12</u> , 19 <u>54</u> , to <u>7/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>56</u> , and that death occurred at <u>9:50 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard A. Fitzguald</u> M.D.				ADDRESS (Street, city or town, state) <u>9620 Old Bladensburg Rd. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Denison, Texas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>July 10, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Severe</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

9561 11 706

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7579 CERTIFICATE OF DEATH

67553

Reg. Dist. No. 342

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Height.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Height.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3704 Gaither</u>				d. STREET ADDRESS <u>2704 Gaither St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH JANE WILLIAMS</u>				4. DATE OF DEATH Month Day Year <u>7 10 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 11, 1869</u>	
9. AGE (In years last birthday) yrs. <u>87</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MAYSVILLE KY</u>	
12. FATHER'S NAME <u>CHARLES DAUENPORT</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. MOTHER'S MAIDEN NAME <u>AMELIA BROWNING</u>				14. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>EDWARD CARROLL 2704 Gaither St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10/11, 1955</u> , to <u>7/10, 1956</u> , that I last saw the deceased alive on <u>7/5, 1956</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Lenarduzzi</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2901 Fairlawn St 7/10/56</u>			
PHYSICIAN'S NAME (Type) <u>David Lenarduzzi</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 14-1956</u>		<u>MAYSVILLE</u>		<u>MAYSVILLE KY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam Lee & Sons</u>				ADDRESS <u>300-4th St. N.E. Wash DC</u>		24a. REC'D BY REGISTRAR <u>7-13-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

CERTIFICATE OF DEATH

PORTLAND STATE DEPARTMENT OF HEALTH - JUNE 18

<p>George (George)</p> <p>Hillcrest Hotel</p> <p>2704 - 1/2 - 1/2 - 1/2</p> <p>ELIZABETH</p> <p>Female White</p> <p>Flowerswick</p> <p>Charles Davenport</p> <p>No No</p>	<p>Williams</p> <p>Hillcrest Hotel</p> <p>2704 - 1/2 - 1/2 - 1/2</p> <p>DANE WILLIAMS</p> <p>MARCH 11 1869</p> <p>WASQUILLE</p> <p>Amelia Browning</p> <p>Edmund Garrett 2704 - 1/2 - 1/2 - 1/2</p>
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BUREAU V. 1

JUL 16 1956

RECEIVED

James J. Williams
2704 - 1/2 - 1/2 - 1/2

WASQUILLE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7538

CERTIFICATE OF DEATH

Reg. Dist. No.

07554

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB 26 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen. Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle A. Last Williams				4. DATE OF DEATH Month July Day 18 Year 19 56			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17/79	9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired Telephone Co				10b. KIND OF BUSINESS OR INDUSTRY Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Job B. Williams				14. MOTHER'S NAME Cora B. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 304-07-4115		17. INFORMANT Carolyn Wells	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism with multiple infarcts 602 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia with bilateral hydronephrosis DUE TO (c) Nephrolithiasis							INTERVAL BETWEEN ONSET AND DEATH 24 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic osteoarthritis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 5 p. m. Month 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 6 , 19 54 to July 18 , 19 56 that I last saw the deceased alive on July 18 , 19 56 , and that death occurred at 9:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. C. Hageage				ADDRESS (Street, city or town, state) Md. Rainier, Md.			
PHYSICIAN'S NAME (Type) C. C. Hageage				DATE SIGNED July 20 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/23/56		22c. NAME OF CEMETERY OR CREMATORY Woodland		22d. LOCATION (City, town, or county) (State) Ironton, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home				ADDRESS 3200 - R. I Ave		24a. REC'D BY REGISTRAR July 20 1956	
				24b. REGISTRAR'S SIGNATURE D. H. Hedrick			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1956

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Place of death		9. Cause of death		10. Manner of death	
11. Signature of physician		12. Signature of registrar		13. Signature of informant		14. Signature of witness		15. Signature of funeral director	
16. Name of funeral home		17. Name of cemetery		18. Name of burial place		19. Name of burial place		20. Name of burial place	
21. Name of burial place		22. Name of burial place		23. Name of burial place		24. Name of burial place		25. Name of burial place	
26. Name of burial place		27. Name of burial place		28. Name of burial place		29. Name of burial place		30. Name of burial place	
31. Name of burial place		32. Name of burial place		33. Name of burial place		34. Name of burial place		35. Name of burial place	
36. Name of burial place		37. Name of burial place		38. Name of burial place		39. Name of burial place		40. Name of burial place	
41. Name of burial place		42. Name of burial place		43. Name of burial place		44. Name of burial place		45. Name of burial place	
46. Name of burial place		47. Name of burial place		48. Name of burial place		49. Name of burial place		50. Name of burial place	
51. Name of burial place		52. Name of burial place		53. Name of burial place		54. Name of burial place		55. Name of burial place	
56. Name of burial place		57. Name of burial place		58. Name of burial place		59. Name of burial place		60. Name of burial place	
61. Name of burial place		62. Name of burial place		63. Name of burial place		64. Name of burial place		65. Name of burial place	
66. Name of burial place		67. Name of burial place		68. Name of burial place		69. Name of burial place		70. Name of burial place	
71. Name of burial place		72. Name of burial place		73. Name of burial place		74. Name of burial place		75. Name of burial place	
76. Name of burial place		77. Name of burial place		78. Name of burial place		79. Name of burial place		80. Name of burial place	
81. Name of burial place		82. Name of burial place		83. Name of burial place		84. Name of burial place		85. Name of burial place	
86. Name of burial place		87. Name of burial place		88. Name of burial place		89. Name of burial place		90. Name of burial place	
91. Name of burial place		92. Name of burial place		93. Name of burial place		94. Name of burial place		95. Name of burial place	
96. Name of burial place		97. Name of burial place		98. Name of burial place		99. Name of burial place		100. Name of burial place	

BUREAU V. S.

JUL 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7539

CERTIFICATE OF DEATH

07555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges</u>		d. STREET ADDRESS <u>Brandywine</u>	
3. NAME OF DECEASED (Type or print) First <u>Valerie</u> Middle <u>Wills</u> Last <u>Wills</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-56</u>
9. AGE (In years lost birthday) yrs. <u>8</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>8</u> Hours <u>5</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas G. Wills</u>		14. MOTHER'S MAIDEN NAME <u>Pasie V. Smallwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Thomas G. Wills, Brandywine, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia assoc. with</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Icterus of unexplained origin</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>			
21. I certify that I attended the deceased from <u>7-4</u> , 19 <u>56</u> , to <u>7-5</u> , 19 <u>56</u> that I last saw the deceased alive on <u>7-5</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Tuckin</u>		ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type) <u>John W. Tuckin</u>		M.D. <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/6/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>
22d. LOCATION (City, town, or county) <u>Md.</u>		(State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>—</u>			

JUL 10 1956

CERTIFICATE OF DEATH

THE ONE

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR	
JAMES J. HARRIS		Male		45		1898		Boston, Mass.		Carpenter		Heart Disease		Natural		J. J. Harris		J. J. Harris	
11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. SEX OF DECEASED		15. AGE OF DECEASED		16. DATE OF BIRTH		17. PLACE OF BIRTH		18. OCCUPATION		19. CAUSE OF DEATH		20. MANNER OF DEATH	
Boston, Mass.		1945		10:00 AM		Male		45		1898		Boston, Mass.		Carpenter		Heart Disease		Natural	
21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris	

BUREAU A. S.

JUL 10 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7540

CERTIFICATE OF DEATH

07556

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Muirkirk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Matilda</u> Middle <u>Wright</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Oct. 1989</u>		9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Joseph H. Conway</u>				14. MOTHER'S MAIDEN NAME <u>Mama Brewer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Prince George Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRA CEREBRAL Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>3 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 21</u> , 195 <u>6</u> to <u>July 22</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>July 22</u> , 195 <u>6</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donald Comeau</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3503 Penny St MT Rainier MD 7/22/56</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONALD COMEAU</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-25-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Purpus Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Murkirk Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hugh S. Washington</u> ADDRESS <u>467 N St. NW.</u>				24a. REC'D BY REGISTRAR DATE <u>25 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

JUL 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07557

7541

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges Gen. Hosp				d. STREET ADDRESS 2606 Bladensburg Rd. NE			
3. NAME OF DECEASED (Type or print) George L. Wynkoop				4. DATE OF DEATH July 29 1956			
5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-29-55	
9. AGE (In years last birthday) 7		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George wynkoop				14. MOTHER'S MAIDEN NAME Turkish Steele			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Clerical Ind			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 759.3 DUE TO Adrenal Shuntiness to Adrenal Hypoplasia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 29 Jul 1956, to 29 Jul 1956, that I last saw the deceased alive on 29 Jul 1956, and that death occurred at 10:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Maloney M.D.				ADDRESS (Street, city or town, state) 4814-71st Ave. DATE SIGNED 29 Jul 56			
PHYSICIAN'S NAME (Type) THOMAS G. MALONEY				LANDOVER HILLS MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/56		22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) Falls Church Va (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Joseph Jones				ADDRESS Hyattsville Ind		24a. REC'D BY REGISTRAR DATE 8-1-56	
				24b. REGISTRAR'S SIGNATURE A. R. Hanch			

BUREAU V. S.

AUG 1 1956

RECEIVED